-- Auto Accident Information --

Please complete this packet as completely and as accurately as your current condition allows. Where response choices are required, please use a check mark "√" to indicate the most appropriate answer. If a question does not apply to you, please write "N/A" (not applicable). If you are unsure about how to accurately answer a question, write a "?" next to it. Please PRINT all responses and ask for assistance if you have any questions.

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

Age: _____ Date of Birth: _____ Gender: ☐ M ☐ F Marital Status: _____ SS#: ___-___-____

Street Address: _____ City: _____ State: ____ Zip: _____

Home Phone: (___)_____ Mobile Phone: (___)_____ Email Address: _____

Emergency Contact Name: _____ Emergency Phone: (___)_____

Occupation: _____ Employer: _____

Employer's Address: _____ Work Phone: _____

At the time of the collision, who was driving the vehicle you were in? ☐ I was ☐ The person indicated below was driving:

(Do Not Complete This Section If ***You*** Were the Driver) Driver's Name: _____

Driver's Address: _____ Driver's Phone: (___)_____

Was the vehicle registered to you? ☐ Yes ☐ No If not, who was it registered to? _____

Your seating position in the vehicle: ☐ Front Seat ☐ Back Seat / ☐ Left ☐ Right ☐ Center _____

Was anyone else in the vehicle with you at the time of the collision? ☐ Yes ☐ No If yes, identify all persons below:

	Name	*Relationship*	*Age*	*Injured?*
1.	_____	_____	_____	☐ Yes ☐ No ☐ Unsure
2.	_____	_____	_____	☐ Yes ☐ No ☐ Unsure
3.	_____	_____	_____	☐ Yes ☐ No ☐ Unsure
4.	_____	_____	_____	☐ Yes ☐ No ☐ Unsure

Were you on the job at the time of the collision? ☐ Yes ☐ No If yes, was it reported to your employer? ☐ Yes ☐ No

Location of the accident: _____

What were the road and weather conditions like at the time? _____

Please describe, in detail, how the accident happened: _____

_____

_____

Please diagram the accident below:

Total number of vehicles involved in the collision: _____

Total number of impacts to your vehicle: _____

Side(s) of your vehicle impacted: _____

Were you wearing a lap & shoulder belt? ☐ Yes ☐ No

Was there a head restraint? ☐ Yes ☐ No

At impact, was head forward of head restraint? ☐ Yes ☐ No

At impact, was your head rotated? ☐ Yes ☐ No

At impact, was your torso rotated? ☐ Yes ☐ No

At impact, was your body leaning forward? ☐ Yes ☐ No

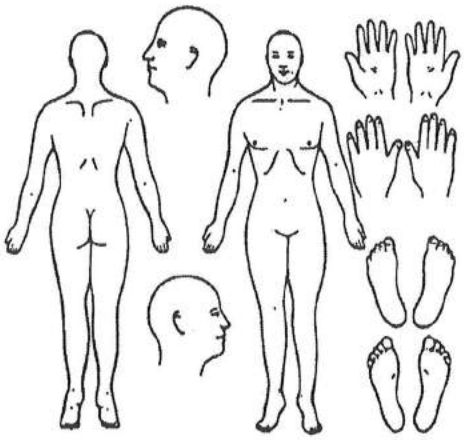
Did you anticipate the impact? ☐ Yes ☐ No

Estimated speed of YOUR vehicle at impact: _____ mph

Estimated speed of OTHER vehicle at impact: _____ mph

Did you strike anything within the vehicle? ☐ Yes ☐ No If yes, please identify the item struck in the vehicle from the list below. Also, please draw a line from the item impacted to the part of the body struck.

- ☐ Airbag
- ☐ Dashboard
- ☐ Windshield
- ☐ Steering wheel
- ☐ Gear selector
- ☐ Head restraint
- ☐ Inner door panel
- ☐ Ceiling
- ☐ Armrest
- ☐ _____
- ☐ _____



Comments

Did the seat you were in break and/or fall backwards from the impact? ☐ Yes ☐ No Explain: _____

Did any windows break in your vehicle? ☐ Yes ☐ No If yes, please identify: _____

Was there any "flying" glass from the impact? ☐ Yes ☐ No If yes, please identify: _____

Were there any: Cuts? ☐ Yes ☐ No / Bruises? ☐ Yes ☐ No / Abrasions? ☐ Yes ☐ No / Photos taken? ☐ Yes ☐ No

If yes, please describe: _____

_____

Make and model of the vehicle you were in: _____ Year: _____

Describe any damage done to the vehicle you were in: _____

_____

_____

_____ Photos taken? ☐ Yes ☐ No

Make and model of the other vehicle(s): _____ Year: _____

Describe any damage done to the other vehicle(s): _____

_____

_____

_____ Photos taken? ☐ Yes ☐ No

After impact, did you: lose consciousness at any time? ☐ Yes ☐ No _____

lose bowel or bladder control? ☐ Yes ☐ No _____

have facial numbness/speech problems? ☐ Yes ☐ No _____

extremity numbness/weakness? ☐ Yes ☐ No _____

Were you able to get out of the vehicle on your own? ☐ Yes ☐ No If not, who helped you? _____

If you were assisted out of your vehicle, describe how you were removed: _____

_____

Did you receive any first aid at the scene? ☐ Yes ☐ No If yes, by whom? _____

If applicable, what first aid was provided to you at the scene? _____

Who was called or came to the accident scene? ☐ Highway Patrol ☐ Local Police ☐ Sheriff ☐ Paramedics ☐ Ambulance ☐ Other _____

Was a report made? ☐ Yes ☐ No If yes, do you have a copy? ☐ Yes ☐ No ☐ Not yet, but I will provide it.

Did you go to the emergency room? ☐ Yes ☐ No Urgent care? ☐ Yes ☐ No Doctor's office? ☐ Yes ☐ No

If you answered "yes" to any of the above questions, please identify where you went and who attended you there: _____

What was done for you there?

Exam:	☐ Yes	☐ No	Pain medication:	☐ Yes	☐ No
X-ray:	☐ Yes	☐ No	Anti-inflammatories:	☐ Yes	☐ No
MRI:	☐ Yes	☐ No	Muscle relaxants:	☐ Yes	☐ No
CT:	☐ Yes	☐ No	Supports/Braces:	☐ Yes	☐ No

What diagnoses were you given? _____

Were you told to do anything by the attending doctor? ☐ Yes ☐ No If yes, please indentify: _____

Were you hospitalized at any time as a result of the injuries you sustained from the accident? ☐ Yes ☐ No If yes, please identify the name and location of the hospital, entry date, exit date, and the name of the treating doctor(s): _____

What was done for you at the hospital? _____

Describe symptoms:

Immediately after the accident: _____

Later that same day: _____

The next day: _____

Have you seen any other health care professional since the first day of the accident? ☐ Yes ☐ No If yes, please complete the section below: *(Begin with the person you saw first and proceed to the most recent.)*

Name	Title	Dates seen	What was done for you?

Please identify any other treatment for this injury (check all that apply): *(specify)*

- ☐ Heat
- ☐ Cold
- ☐ Rest
- ☐ Exercise
- ☐ Stretches
- ☐ Massage
- ☐ Other: _____
- ☐ Slept in different position
- ☐ Slept on a different surface
- ☐ Minimized motions of the head
- ☐ Minimized overhead work
- ☐ Minimized lifting
- ☐ Minimized sitting
- ☐ Restricted home activities: _____
- ☐ Restricted work activities: _____
- ☐ Continued prescription meds: _____
- ☐ Took over-the-counter meds: _____

Normal job duties: _____

Current job duties: _____

Have you missed any work and/or job opportunities as a result of your auto accident? ☐ Yes ☐ No Please identify: _____

Have you had any injury or significant illness ***since*** the auto injury? ☐ Yes ☐ No If yes, please describe: _____

_____

Have you had any significant injury or illness, of any type, ***prior*** to the auto injury? ☐ Yes ☐ No If yes, what was the nature of the problem and when did it occur? _____

_____

_____

If professional care was rendered for the above prior injury or condition, how long were you treated, by whom, and what was done for you? Was it fully resolved? _____

_____

_____

Have you ever had any award of permanent disability/impairment for any prior condition/injury? ☐ Yes ☐ No If yes, please identify what the award was, when it was received, and for what condition/injury: _____

_____

Are you currently under any other doctor's care? ☐ Yes ☐ No If yes, who is the doctor and what is he/she treating you for? _____

_____

What medications, prescribed or not, are you currently taking to treat any condition or injury ***unrelated*** to your auto accident injuries? _____

_____

Have you ever served in the armed forces? ☐ Yes ☐ No If yes, what were the dates of service and what type of discharge did you receive? _____

Prior to this auto accident, have you ever been diagnosed as having any of the following? Circle *all* that apply.

Whiplash	Neck Sprain	Spondylolysis	Vertebral Fracture	Rheumatoid Arthritis
Scoliosis	Back Sprain	Facet Arthrosis	Metabolic Disorder	Ankylosing Spondylitis
Spondylosis	Osteoporosis	Disc Protrusion	Diabetes Type 1 or 2	Foraminal Encroachment
Fibromyalgia	Pagets Disease	Spinal Infection	Any Spinal Anomaly	Carpal Tunnel Syndrome
TMJ Problem	Spinal Stenosis	Spondylolisthesis	Extremity Dislocation	Degenerative Disc Disease

Comments: _____

_____

Before the auto accident, how would you rate your overall health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Do you currently use tobacco products? ☐ Yes ☐ No If yes, how much do you smoke per day? _____

Do you currently drink alcohol? ☐ Yes ☐ No If yes, how much and how often? _____

Did you have any recreational activities or hobbies before the accident? ☐ Yes ☐ No If yes, what were they and how often did you do them? _____

_____

Please provide any additional information you believe is important to your case: _____

_____

_____

_____

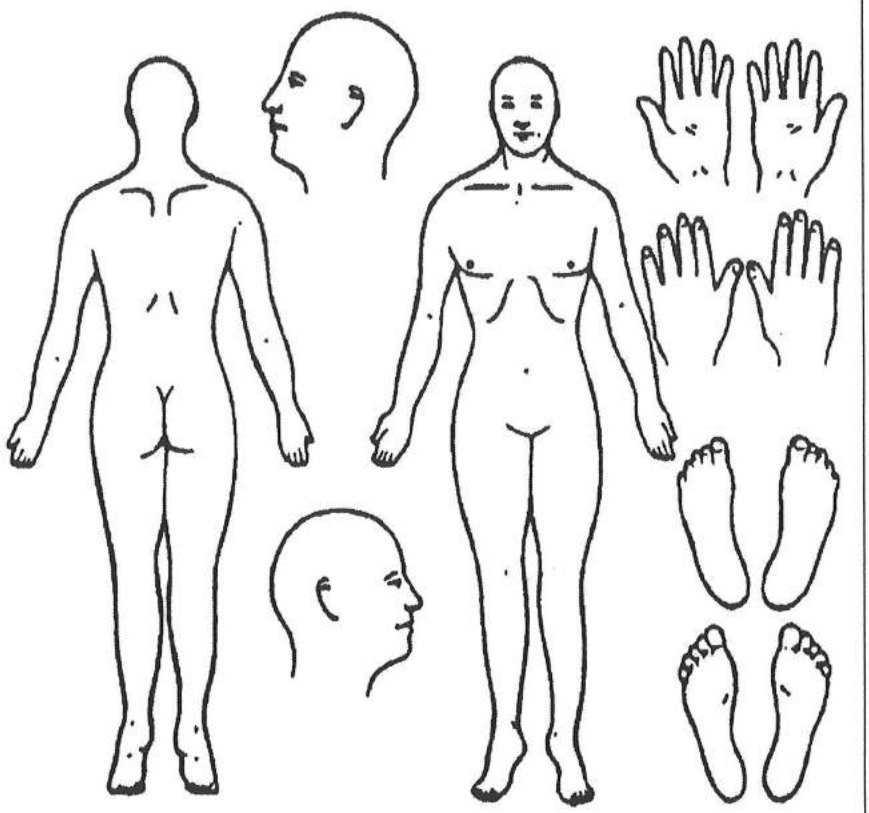
_____

Current Medical Complaints

It is important to carefully identify your current complaints. Use the body diagram to identify the location and nature of your symptoms. **Please use the key below.**

+++ = sharp or stabbing
~~~ = burning
ooo = pins and needles
vvv = dull or aching
/// = numbness

-- Comments --



--- Circle the number of any and all symptoms that have appeared, even briefly, since the time of the auto collision.---

1. Nausea
2. Vertigo/dizziness/lightheadedness
3. Neck pain/stiffness
4. Headache
5. Photophobia (sensitivity to light)
6. Phonophobia (sensitivity to loud noises)
7. Tinnitus (ringing in the ears)
8. Impaired memory
9. Difficulty concentrating
10. Impaired comprehension or awareness
11. Prolonged, unexplained staring
12. A feeling of having a "brain fog"
13. Forgetfulness
14. Impaired logical thinking
15. Difficulty with new or abstract concepts
16. Insomnia (difficulty sleeping)
17. Fatigue
18. Apathy
19. Outburst of anger
20. Mood swings
21. Depression
22. Loss of libido (sex drive)
23. Personality change
24. Intolerance to alcohol

25. Clicking in the jaw
26. Popping in the jaw
27. Locking of the jaw
28. Side shift of the jaw upon opening
29. Inability to open the mouth wide
30. Pain on chewing
31. Facial pain
32. Grinding your teeth
33. Jaw muscles sore upon waking
34. Chewing on one side of your mouth
35. Painful teeth
36. Loose or chippped teeth
37. Tender muscles in front of the neck

38. Pain on swallowing
39. Difficulty swallowing
40. Intolerance to strong odors
41. Decreased ability to smell
42. Decreased ability to taste
43. Vision changes

44. Blood in the urine
45. Pain over one or both kidneys
46. Urinary problems

47. Loss of weight
48. Weight gain
49. Nightmares
50. Pain on inhaling deeply
51. Indigestion
52. Diarrhea
53. Constipation
54. Vomiting
55. Nervousness
56. Cramping
57. Knees buckling unexpectedly
58. Dropping things easily
59. Weakness in the arms or legs

Other Symptoms and/or Comments:

_____

_____

_____

_____

_____

_____

Anaheim Hills Chiropractic & Sports Injury Clinic
Timothy R. Noble, DC, DACBSP, CSCS
5769-P Santa Ana Canyon Rd Anaheim Hills, CA 92807 (714) 974-3700 Fax (714) 282-1830

Informed Consent to Chiropractic Treatment

As with any healthcare procedure there are certain complications which may arise during chiropractic manipulation and therapy. Doctors of Chiropractic are required to advise patients that there are risks associated with such treatment. In particular you should note:

1.) Some patients may experience some stiffness or soreness following the first few days of treatment.
2.) Some types of manipulation have been associated with injuries to the arteries of the neck leading or contributing to serious complications including stroke. This occurrence is exceptionally rare and remote. However, you are being informed of the possibility regardless of the extreme remote chance.
3.) I will make every effort to screen for any contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.
4.) Other complications may include fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns.

The probabilities of these complications are rare and generally result from some underlying weakness of the bone or tissue which I check for during the history, examination, and x-ray (when warranted).

I acknowledge I have had the opportunity to discuss associated risks as well as the nature and purpose of treatment with my chiropractor.

I consent to the chiropractic treatments offered or recommended to me by my chiropractor, including spinal manipulation. I intend this consent to apply to all my present and future chiropractic care.

_____ _____
Patient Signature Patient Name

_____ _____
Witness Signature Date

PATIENT NAME:_____

Check each of the activities which you have difficulty performing and/ or can perform only with pain. (There is no particular priority in the order presented.)

HOUSEWORK

__Doing laundry
__Making beds
__Vacuuming
__Washing dishes
__Ironing
__Carrying Groceries
__Caring for pets
__Cooking
__Other_____

YARDWORK

__Mowing Lawn
__Shoveling snow
__Raking Leaves
__Gardening

PERSONAL GROOMING

__Combing hair
__Shaving
__In/Out bathtub
__ Brushing teeth
__Other_____

TRAVEL

__Driving
__Riding (Passenger)

Minutes per day
Type vehicle
Auto_____
Train_____
Bus_____
Truck_____
Airplane_____

Activities of Daily Living

GENERAL

__Walking
__Standing
__Running
__Sitting
__Lifting children
__Bending
__Climbing stairs
__Reading
__Lying in Bed
__Chewing
__Sports: List_____

__Getting in and our of auto
__Playing piano
__Using typewriter/computer
__Kneeling
__Sexual intercourse
__Exercising
__Sleeping
__Using telephone
__Sitting in recliner
__Swimming

OTHER: Please list any other difficulties you are experiencing with activities you have engaged in since your condition arose:_____

_____

Sign_____ Date_____

ACTIVITIES OF DAILY LIVING

Timothy R. Noble, D.C., D.A.C.B.S.P., Q.M.E.
Sports Chiropractor ● Orthopedics

ANAHEIM HILLS CHIROPRACTIC & SPORTS INJURIES CLINIC
EST 1986

Third Party Lien and Direct Payment to Provider

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

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

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

Date _____ Patient Signature _____

The undersigned Insurance company 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 and fully compensate said doctor above and below named and make payment payable directly to said doctor.

Date _____ _____

Insurance Company Representative

_____

Print First and Last Name

Please date, sign and return one copy to the doctor's office below.

Diplomate of American Chiropractic Board of Sports Physicians

State-Appointed Qualified Medical Examiner

Certified Industrial Disability Evaluator

Exercise Rehabilitation

5769-P E. Santa Ana Canyon Rd. ● Anaheim Hills, CA 92807 ● Tel (714) 974-3700 ● Fax (714) 282-1830
www.anaheimhillschiropractic.com

Anaheim Hills Chiropractic & Sports Injuries Clinic

5769-P East Santa Ana Canyon Rd. • Anaheim Hills, CA 92807 • (714) 974-3700 • Fax (714) 282-1830

Timothy R. Noble, D.C., C.C.S.P., Q.M.E.
Sports Chiropractor • Orthopedics
Qualified Medical Examiner

Recession of Attorney Assignment of Benefits

To Whom It May Concern:

Í,_____ being the insured on this policy, specifically direct you, my insurance company to rescind and cancel any assignment given to you by my attorney on the above claim.

I also request that reimbursement for **ALL services be paid DIRECTLY to my doctor**, the provider of these services, under the terms of my contract with this company. NO other third party should receive payment of my medical/chiropractic bills except treating doctor for the remainder of this claim.

_____ _____

Patient/Insured Signature Date

REQUEST FOR MEDICAL RECORDS

PATIENT NAME: _____ DATE: _____

Patient Identification:	Social Security No/ID: Date of Birth: Medical Record No:

REQUEST RECORDS FROM (Name and address of Doctor/Facility where patient's medical records are presently located):

Name:	
Address:	

SEND THE SPECIFIED AND AUTHORIZED MEDICAL RECORDS TO:

Doctor's Name:	Timothy R. Noble DC, DACBSP, CSCS
Address:	5769-P E. Santa Ana Canyon Road, Anaheim, CA 92807
Telephone:	714-974-3700

WHAT MEDICAL RECORDS ARE AUTHORIZED TO DISCLOSE AND MAIL:

☐ All Medical Records
☐ X-Ray/MRI/CT reports
☐ EMG, SSEP, Nerve Conduction, Laboratory tests, Diagnostic Test Reports
☐ Other _____

SPECIFIC DATES AUTHORIZED FOR RECORDS RELEASE

Medical records from (insert date) _____ to (insert date)_____
If no dates are indicated, this authorization will remain valid for 30 days.

PURPOSE OF RELEASE OF INFORMATION

☐ At request of above patient
☐ Other:

I hereby request and authorize disclosure of the above protected health information in my medical records kept at your office or facility to be photocopied, released and mailed to above doctor /facility at the indicated address for the specified dates. I understand that the Health Insurance Portability and Accountability Act (HIPAA) applies to my medical records and protected health information. I expect the holder of my medical records to mail my specified medical records as soon as reasonably possible. According to Section 123.110 of the California Health & Safety Code, these records/films must be transmitted within 15 days from the receipt of this notice. This authorization may be revoked by me, at any time, by advising the doctor's office (privacy officer) of this revocation in writing, except to the extent a source of information has already relied on it. I have been advised that if I choose to not sign this authorization that it will not have any adverse effect on my treatment, eligibility for benefits, enrollment, or payment.

EXPIRES: This authorization is good for 12 months from the date signed for the disclosure of the information described above.

*This authorization does not apply to any records/notes regarding HIV/AIDS, communicable disease, alcohol or drug treatment, mental health information, behavioral health care, domestic violence, genetic testing, and psychiatric or psychotherapy notes.

Patient Name (Print Clearly): _____

Individual Authorizing Disclosure: _____/_____
Signature **Date**

If not signed by the patient, specify basis for your authority to sign: ☐ Parent of minor, ☐ Guardian

This general and specific authorization to disclose was developed to comply with the provisions regarding disclosure of medical information under HIPAA: 45 CFR parts 160 and 164, 42 CFR part 2, 38 CFR, 34 CFR parts 99 and 300, and State law.

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION-RECORDS

Last Name:	**MI:**	**First Name:**	
Home Address:	City:	State:	Zip:
Date Birth:	Social Security No/ID:		

The 1996 Health Insurance Portability and Accountability Act (HIPAA) requires that all health care providers comply with patient privacy and security laws (45 CFR 164). Patient confidentiality and privacy/security applies to any **protected health information (PHI).** Federal Laws now require signed and dated authorization from patients in several aspects of patient care, transmission of medical information, confidentiality, and patient rights relating to their release of medical records. In order for this authorization to be valid you must complete this entire form, indicate an expiration date (example: 6 months/1 year) or an event (examples: at the conclusion of care, when my case is closed or at the end of my plan enrollment) and sign/date your authorization. I, or my authorized representative, request and authorize that my health information be released to the following sources as set forth on this form. This authorization cannot be used to release psychotherapy or psychiatric notes. Check boxes below for specific description of my health information to be disclosed:

This Authorization will expire. Event examples are; case closure or termination of plan benefits. **Check only one box.**
☐ One year from the date it is signed or ☐ Insert date or event: _____
Medical records from (insert date) _____ to (insert date)_____

_____ Initial. I authorize release of entire set of medical records/notes, including: intake forms, history, diagnosis, treatment, consultation records, neurological/laboratory scan or test results, disabilities, billing-claim payment information, reports, radiological films/test results, progress notes, photographs, correspondence, telephone messages, and medical records from other sources.

_____ Initial ☐ **Yes,** ☐ **No**: [**Special Limitations for Release of Sensitive Protected Health Information.]** I specifically authorizes the release of HIV/AIDS test results, sexually transmitted or communicable disease notes (such as Hepatitis or venereal diseases), drug, alcohol, or substance abuse or treatment notes, behavioral, mental health disabilities or developmental disability records/notes (including mental retardation), abuse, neglect or domestic violence, or genetic testing information. If authorized, the recipient is prohibited from redisclosing such information without my authorization unless permitted by state and federal law. I have to right to request a list of people who may receive this sensitive information.

List any other special restrictions or limitations:_____

RELEASE AUTHORIZATIONS (Patient, please initial the following section(s) that apply to you)
_____ **Initial. Insurance-Medical Plans**. I authorize said doctor to communicate with, send updated billing, reports, and release all medical records, and treatment records to the following insurance companies and/or governmental agencies listed below:
List: _____

_____ **Initial. Attorney** Name _____ I authorize said doctor to communicate with, send billing information, reports, all medical records, and insurance records to my retained attorney until the case is closed/conclusion of litigation and my billing and requests for records have concluded for this specific injury. Date of injury: _____

_____ **Initial.** I authorize said doctor to verbally communicate with the following **person(s)** about my health condition and recommendations. Name of person(s) and contact information: _____

- ✓ I can revoke this authorization at any time by giving my written revocation in writing to said doctor's office. My revocation is not effective as to disclosures already made and actions already taken in reliance upon this authorization.
- ✓ This authorization is voluntary. The disclosing health care provider/plan/may NOT condition treatment, enrollment in the health plan or eligibility for benefits on whether I sign this authorization.
- ✓ Information disclosed under this authorization may be redisclosed by the recipient and may no longer be protected by federal and state law.

PRINT PATIENT NAME: _____
☐ **LEGAL GUARDIAN/PARENT NAME/RELATIONSHIP:** _____

DATE: _____ **Signature:** _____

Timothy R. Noble DC, DACBSP, CSCS-Anaheim Hills Chiropractic and Sports Injuries Clinic

Anaheim Hills Chiropractic and Sports Injuries Clinic

Notice of Privacy Practices

Effective September 23, 2013]

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THAT INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

The Practice (the "Practice"), in accordance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, (the "Privacy Rule") and applicable state law, is committed to protecting the privacy of your protected health information ("PHI"). PHI includes information about your health condition and the care and treatment you receive from the Practice. The Practice understands that information about your health is personal. This Notice explains how your PHI may be used and disclosed to third parties. This Notice also details your rights regarding your PHI. The Practice is required by law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and practices with respect to your PHI. The Practice is also required by law to abide by the terms of this Notice.

HOW THE PRACTICE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

The Practice, in accordance with this Notice and without asking for your express consent or authorization, may use and disclose your PHI for the purposes of:

For Treatment – We may use your PHI to provide you with treatment. We may disclose your PHI to doctors, nurses, technicians, clinicians, medical students, hospitals and other health facilities involved in or consulting in your care. We may also disclose information about you to people outside the practice, such as other health care providers involved in providing treatment to you, and to people who may be involved in your care, such as family members, clergy, or others we use to provide services that are part of your care. If we refer you to another health care provider, we would, as part of the referral process share PHI information about you. For example, if you were referred to a specialist, we would contact the doctor's office and provide such information about you to them so that they could provide services to you.

For Payment – We may use and disclose your PHI so we can be paid for the services we provide to you. For example, we may need to give your insurance company information about the health care services we provided to you so your insurance company will pay us for those services or reimburse you for amounts you have paid. We also may need to provide your insurance company or a government program, such as Medicare or Medicaid, with information about your condition and the health care you need to receive prior approval or to determine whether your plan will cover the services.

For Health Care Operations – We may use and disclose your PHI for our own health care operations and the operations of other individuals or organizations involved in providing your care. This is necessary for us to operate and to make sure that our patients receive quality health care. For example, we may use information about you to review the services we provide and the performance of our employees in caring for you.

OTHER USE & DISCLOSURES THAT ARE REQUIRED OR PERMITTED BY LAW

The Practice may also use and disclose your PHI without your consent or authorization in the following instances:

Appointment Reminders -We may use and disclose your PHI to remind you by telephone or mail about appointments you have with us, annual exams, or to follow up on missed or cancelled appointments.

Individuals Involved in Your Care or Payment for Your Care – We may disclose to a family member, other relative, a close friend, or any other person identified by you. Certain limited PHI that is directly related to that person's involvement with your care or payment for your care. We may use or disclose your PHI to notify those persons of your location or general condition. This includes in the event of your death unless you have specifically instructed us otherwise. If you are unable to specifically agree or object, we may use our best judgment when communicating with your family and others.

Disaster Relief - We also may use or disclose your PHI to an authorized public or private entity to assist in disaster relief efforts. This will be done to coordinate information with those organizations in notifying a family member, other relative, close friend or other individual of your location and general condition.

De-identified Information – The Practice may use and disclose health information that may be related to your care but does not identify you and cannot be used to identify you.

Business Associate – The Practice may use and disclose PHI to one or more of its business associates if the Practice obtains satisfactory written assurance, in accordance with applicable law, that the business associate will appropriately safeguard your PHI. A business associate is an entity that assists the Practice in undertaking some essential function, such as a billing company that assists the office in submitting claims for payment to insurance companies.

Personal Representative – The Practice may use and disclose PHI to a person who, under applicable law, has the authority to represent you in making decisions related to your health care.

Emergency Situations – The Practice may use and disclose PHI for the purpose of obtaining or rendering emergency treatment to you provided that the Practice attempts to obtain your Consent as soon as possible: The Practice may also use and disclose PHI to a public or private entity authorized by law or by its charter to assist in disaster relief efforts, for the purpose of coordinating your care with such entities in an emergency situation.

Public Health and Safety Activities – The Practice may disclose your PHI about you for public health activities and purposes. This includes reporting information to a public health authority that is authorized by law to collect or receive the information. These activities generally include:

- To prevent or control disease, injury or disability
- To report births or deaths
- To report child, elder, or dependent adult abuse or neglect
- To report reactions to medications or problems with products
- To notify people of recalls of products they may be using
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

Victims of Abuse, Neglect or Domestic Violence – We may disclose your PHI to a government authority authorized by law to receive reports of abuse, neglect, or domestic violence, if we believe an adult or child is a victim of abuse, neglect, or domestic violence. This will occur to the extent the disclosure is (a) required by law, (b) agreed to by you, (c) authorized by law and we believe the disclosure is necessary to prevent serious harm, or, (d) if you are incapacitated and certain other conditions are met, a law enforcement or other public official represents that immediate enforcement activity depends on the disclosure.

Health Oversight Activities – We may disclose your PHI to a health oversight agency for activities authorized by law, including audits, investigations, inspections, licensure or disciplinary actions. These and similar types of activities are necessary for appropriate oversight agencies to monitor the nation's health care system, government benefit programs, and for the enforcement of civil rights laws.

Judicial and Administrative Proceedings – We may disclose your PHI in response to a court or administrative order. We also may disclose information about you in response to a subpoena, discovery request, or other legal process but only if efforts have been made to tell you about the request or to obtain an order protecting the information to be disclosed.

Disclosures for Law Enforcement Purposes – We may disclose your PHI to law enforcement officials for these purposes:

- As required by law
- In response to a court, grand jury or administrative order, warrant or subpoena
- To identify or locate a suspect, fugitive, material witness or missing person
- About an actual or suspected victim of a crime if, under certain limited circumstances, we are unable to obtain that person's agreement
- To alert a potential victim or victims or intending harm ("duty to warn")
- To alert law enforcement officials to a death if we suspect the death may have resulted from criminal conduct
- About crimes that occur at our facilities
- To report a crime, a victim of a crime or a person who committed a crime in emergency circumstances

To Avert Serious Threat to Health or Safety – We will use and disclose your PHI when we have a "duty to report" under state or federal law because we believe that it is necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure would be to help prevent a threat.

Coroners, Medical Examiners and Funeral Directors – We may disclose your PHI to a coroner or medical examiner for purposes such as identifying a deceased person and determining cause of death. We also may disclose information to funeral directors so they can carry out their duties.

Organ, Eye or Tissue Donation – To facilitate organ, eye or tissue donation and transplantation, we may disclose your PHI to organizations that handle organ procurement, banking or transplantation.

Workers Compensation – We may disclose your PHI to the extent necessary to comply with worker's compensation and similar laws that provide benefits for work-related injuries or illness without regard to fault.

Special Government Functions – If you are a member of the armed forces, we may release your PHI as required by military command authorities. We may also release information about foreign military authority. We may disclose information about you to authorized federal officials for intelligence, counter-intelligence and other national security activities authorized by law.

Research – We may use and/or disclose your PHI for research projects that are subject to a special review process. If researchers are allowed access to information that information that identifies who you are, we will ask for your permission.

Fundraising – We may contact you with respect to fundraising campaigns. If you do not wish to be contacted for fundraising campaigns, please notify our Privacy Officer in writing.

AUTHORIZATION

The following uses and/or disclosures specifically require your express written permission:

Marketing Purposes – We will not use or disclose your PHI for marketing purposes for which we have accepted payment without your express written permission. However, we may contact you with information about products, services or treatment alternatives directly related to your treatment and care.

Sale of Health Information – We will not sell your PHI without your written authorization. If you do authorize such a sale, the authorization will disclose that we will receive compensation for the information that you have authorized us to sell. You have the right to revoke the authorization at any time, which will halt any future sale.

Uses and/or disclosures other than those described in this Notice will be made only with your written authorization. If you do authorize a use and/or disclosure, you have the right to revoke that authorization at any time by submitting a revocation in writing to our Privacy Officer. However, revocation cannot be retroactive and will only impact uses and/or disclosures after the date of revocation.

YOUR RIGHTS

Right to Revoke Authorization – You have the right to revoke any Authorization or consent you have given to the Practice, at any time. To request a revocation, you must submit a written request to the Practice's Privacy Officer.

Right to Request Restrictions – You have the right to request that we restrict the uses or disclosures of your information for treatment, payment or healthcare operations. You may also request that we limit the information we share about you with a relative or friend of yours. You also have the right to restrict disclosure of information to your commercial health insurance plan regarding services or products that you paid for in full, out-of-pocket and we will abide by that request unless we are legally obligated to do so.

We are not required to agree to any other requested restriction. If we agree, we will follow your request unless the information is needed to a) give you emergency treatment, b) report to the Department of Health and Human Services, or c) the disclosure is described in the "Uses and Disclosures That Are Required or Permitted by Law" section. To request a restriction, you must have your request in writing to the Practice's Privacy Officer. You must tell us: a) what information you want to limit, b) whether you

want to limit use or disclosure or both and c) to whom you want the limits to apply. Either you or we can terminate restrictions at a later date.

Right to Receive Confidential Communications – You have the right to request that we communicate your PHI in a certain way or at a certain place. For example, you can ask that we only contact you by mail or at work.

If you want to request confidential communications you must do so in writing to our Practice's Privacy Officer and explain how or where you can be contacted. You do not need to give us a reason for your request. We will accommodate all reasonable requests.

Right to Inspect and Copy – You have the right to inspect and request copies of your information.

To inspect or copy your information, you may either complete an Authorization to Release/Obtain Information form or write a letter of request, stating the type of information to be released, the date(s) of service being requested, the purpose of the request, and whether you wish to review the record or receive copies of the requested information in your preferred format. We will abide by your request in the format you have requested, if we are able to do so. If we cannot provide your records to you in the requested format, we will attempt to provide them in an alternative format that you agree to. You may also request that your records be sent to another person that you have designated in writing. Direct this request to the Practice's Privacy Officer. You may be charged a fee for the cost of copying, mailing or other expenses related with your request.

We may deny your request to inspect and copy information in a few limited situations. If you request is denied, you may ask for our decision to be reviewed. The Practice will choose a licensed health care professional to review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of that review.

Right to Amend – If you feel that your PHI is incorrect, you have the right to ask us to amend it, for as long as the information is maintained by us. To request an amendment, you must submit your request in writing to the Practice's Privacy Officer. You must provide a reason for the amendment.

We may deny your request for an amendment if it is not in writing or does not include a reason for wanting the amendment. We also may deny your request if the information: a) was not created by us, unless the person or entity that created the information is no longer available to amend the information, b) is not part of the information maintained by the Practice, c) is not information that you would be permitted to inspect and copy or d) is accurate and complete.

If your request is granted the Practice will make the appropriate changes and inform you and others, as needed or required. If we deny your request, we will explain the denial in writing to you and explain any further steps you may wish to take.

Right to an Accounting of Disclosures – You have the right to request an accounting of disclosures. This is a list of certain disclosures we have made regarding your PHI. To request an accounting of disclosures, you must write to the Practice's Privacy Officer. Your request must state a time period for the disclosures. The time period may be for up to six years prior to the date on which you request the list, but may not include disclosures made before April 14, 2003.

There is no charge for the first list we provide to you in any 12-month period. For additional lists, we may charge you for the cost of providing the list. If there will be a charge, we will notify you of the cost in advance. You may withdraw or change your request to avoid or reduce the fee.

Certain types of disclosures are not included in such an accounting. These include disclosures made for treatment, payment or healthcare operations; disclosures made to you or for our facility directory; disclosures made with your authorization; disclosures for national security or intelligence purposes or to correctional institutions or law enforcement officials in some circumstances.

Right to a Paper Copy of this Notice – You have the right to receive a paper copy of this Notice of Privacy Practices, even if you have agreed to receive this Notice electronically. You may request a paper copy of this Notice at any time.

Right to File a Complaint – You have the right to complain to the Practice or to the United States Secretary of Health and Human Services (as provided by the Privacy Rule) if you believe your privacy rights have been violated. To file a complaint with the Practice, you must contact the Practice's Privacy Officer. To file a complaint with the United States Secretary of Health and Human Services, you may write to: Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Washington, DC 20201. All complaints must be in writing.

To obtain more information about your privacy rights or if you have questions about your privacy rights you may contact the Practice's Privacy Officer as follows:

Name: Ann Wagner

Address: 5769-P. E. Santa Ana Canyon Road, Anaheim, California, 92807

Telephone No.: 714-974-3700

We encourage your feedback and we will not retaliate against you in any way for the filing of a complaint. The Practice reserves the right to change this Notice and make the revised Notice effective for all health information that we had at the time, and any information we create or receive in the future. We will distribute any revised Notice to you prior to implementation.

I acknowledge receipt of a copy of this Notice, and my understanding and my agreement to its terms.

Patient: _____ Date: _____

PROVIDER'S PERSONAL INJURY ACCEPTANCE POLICIES & PATIENT AGREEMENT TO FOLLOW THOSE POLICIES

As a medical provider ("Provider") willing to treat patients in personal injury matters upon certain conditions being met, we will generally accept your Personal Injury Case when the below conditions are agreed to and kept, though we reserve the right to refuse or discontinue service to anyone and that right remains in effect.

Provider will first bill your auto-med pay/PIP and personal or group insurance. You agree to assign your benefits for direct payment to Provider. If represented by legal counsel, you agree to direct both your attorney and carrier that any such payment is to be paid directly to Provider, and to sign any form Provider needs to accomplish that direct payment.

In the event you are represented by legal counsel and you do not have the above-referenced insurance or ability to personally pay, Provider agrees that treatment will be rendered on a lien basis, which only means that Provider agrees to a delay in being paid, not being paid less; and, provided the below-listed conditions are each agreed and adhered to by you. In the event any of these conditions are not followed, full payment will immediately be owed to Provider.

Please note that when treatment is rendered on a lien basis, you remain directly and fully responsible for all chiropractic bills outstanding and unpaid, in their full amount, including interest accruing on any unpaid sums at the highest legal rate, or ten percent (10%) per annum, whichever is higher. This includes if any settlement or verdict in your Personal Injury Case isn't sufficient to pay the full amount of Provider's invoice plus the accrued interest. Payment is not contingent upon any settlement, judgment, or verdict. You, not your attorney, are ultimately responsible for payment in full to Provider.

The following lists each of the conditions that must be met in order to treat you on a lien basis:

1. You are represented by a duly licensed attorney specializing in personal injury law. If you have not retained an attorney yet, you have advised you are actively seeking, intend to retain an attorney, and you will have the attorney sign the medical lien form provided by this office without modification to that lien form.

2. The merits of your case are established by your attorney and the progress of your case is continually communicated in a timely manner by your attorney to Provider, including immediate notification of any settlement. We expect your attorney (or if no attorney you in the meantime) to provide status updates in writing to us at least every 3 months until our bill is fully paid.

3. If you or your attorney have any problem with the treatment or billing rendered by Provider, that you and your attorney must notify Provider immediately, and at the latest promptly after receiving the first billing statement.

4. Our *Medical Lien Agreement* is signed by you, your attorney and we as your Provider. This helps to ensure our Provider's fees are promptly paid from any full or partial settlement of your claim and protecting us as your medical Provider in the event of delays or non-payment, in exchange for agreeing to treat you and to be paid after

treatment has been rendered.

5. You follow the treatment program recommended by Provider or Provider's associate, and complete that treatment program in a timely manner. In the event you discontinue care or change doctors without approval of us, or fail to follow the recommended treatment plan, payment then becomes immediately due and payable by you personally.

6. All medical insurance and auto-med/PIP payments shall be assigned by you to Provider and not to your attorney. You will use best efforts to instruct your attorney in writing to comply with payment of those "med pay"/PIP entitlements to our office directly.

7. Should all of Provider's fees not be paid by your lawsuit or otherwise in a timely fashion, or if your attorney fails to cooperate or communicate with Provider, accepts any med-pay/PIP without immediately forwarding that med-pay/PIP to Provider, or your attorney seeks to reduce Provider's bill, or you fail to follow any of Provider's policies, then any action by Provider to collect on the amounts owed will include the payment of Provider's attorney's fees and costs, which shall include any attorney's fees incurred attempting to collect the monies owed or otherwise resolving this with you or your attorney prior to the commencement of formal legal action. Provider's legal fees are generally incurred at the rate of approximately $300 per hour.

By my signature below, I as the Patient agree to be contractually bound by all the above referenced policies of Provider.

PROVIDER'S NAME: _____
PATIENT'S NAME: _____
PATIENT SIGNATURE: _____
DATE: _____

DIRECTIVE TO PATIENT'S MEDICAL PROVIDER TO
NOT BILL MY HEALTH INSURANCE

I hereby direct you, as my medical provider, not to bill or utilize my personal health insurance for any of the treatment rendered by you and your office for injuries sustained in the incident for which I am now seeking treatment.

I believe, and have told you as my provider, that the incident was not my fault. I do not wish to be penalized in any manner for someone else's wrongdoing. My health insurance rights may be adversely affected, such as limiting my total number of office visits to a yearly maximum and using them for the injuries from this incident may result in me losing that insurance entitlement for future office visits. Or, I do not wish to be responsible for any co-pays, deductibles or incur costs for non-covered services, or for some other reason personal to me. I desire, and choose, to preserve my health insurance visits and co-pays or deductibles for any similar future medical care where I can then choose to use my healthcare coverage.

Consequently, while you are allowed to bill my auto med-pay policy if med-pay is available, you are instructed not to bill my healthcare insurance. This directive is effective immediately and covers me from the date of my first visit with your office related to this incident, and continues until the conclusion of my treatment for these injuries. I make this directive voluntarily, of my own preference and without any coercion or duress of any kind by you or your staff members.

I understand that by choosing this option, I agree that I shall not rescind this directive once given unless that rescission is given in writing by me within fourteen (14) calendar days of signing this directive. Otherwise, you, as my medical provider, would likely be past the time deadline for the submission of my bills for payment to my health insurer, or I would be creating other problems for the payment of your services under my healthcare plan. I will be solely responsible to notify any attorney I now or later retain of this directive. In the event of any litigation arising under this directive, the prevailing party shall be entitled to recover their reasonable attorney's fees and costs. Venue for any litigation arising out of this incident shall be where the medical services were provided.

_____ _____

Patient Signature Date

Patient Name: _____

MEDICAL LIEN AGREEMENT

PATIENT NAME: _____
DATE OF INJURY/INCIDENT: _____

The named Patient ("Patient") desires medical treatment by the below-named Provider, including all entities related to Provider (collectively, "Provider") for injuries sustained in the above-referenced personal injury incident ("Incident"), and has or shall be retaining the below-referenced Attorney ("Attorney") to seek compensation from a potentially liable "third party". At the request of Patient and/or Attorney, Provider agrees to a delay in being paid, by establishing a creditor-debtor relationship through this contractual Agreement, whereby Provider agrees to provide medical treatment to Patient on a "lien" basis ("Medical Lien"). Provider agrees to wait and be paid promptly upon resolution of the underlying legal matter, or, immediately upon a breach of this Agreement should Patient and/or Attorney fail to comply with the provisions of this Medical Lien.

Provider's Medical Lien is against any and all proceeds arising from the Incident, including, but not limited to, "med pay" or PIP insurance payment(s), case settlement (in whole or in part), judgment, or verdict which may be paid to Patient directly or through Attorney. In exchange for Provider agreeing to delay being fully paid, the Parties to this Medical Lien agree to each of the following:

1. That Provider may release all medical information, billings, treatment notes, etc. concerning Patient's condition and treatment to Patient's insurance company, attorney or insurance adjuster, as well as Provider's attorney or lien rep, in connection with the incident.
2. That Patient and Attorney will notify Provider in writing of any objection or issue as to Provider's fees or charges within ten (10) days of receipt of any interim or individual billing statement.
3. That no modification to this Medical Lien shall be effective unless each such modification (including any stamp, addendum or handwritten change) is initialed by Provider. If such a modification (or addendum) is attempted, but not initialed by Provider and Patient, and Patient continues to treat with Provider, then all parties signing this Medical Lien agree the Medical Lien as originally presented by Provider remains in full force and effect with the original, unmodified language as presented to the Parties by Provider.
4. That there will be no reduction of Provider's outstanding Medical Lien balance without Provider's signed written agreement to a specific dollar amount. Any request for a bill reduction should be made to Provider prior to Patient agreeing to accept any lawsuit settlement. Any reduction duly accepted by Provider is valid and enforceable, provided Provider receives the agreed upon reduction amount within 10 calendar days of Attorney's (or Patient's if no Attorney) receipt of the first settlement funds or sixty 60 calendar days from the date of Provider's written reduction agreement, whichever occurs first. Attorney (or Patient if no Attorney) shall notify Provider in writing by fax or email promptly when payment on the Medical Lien has been transmitted and is responsible for promptly confirming Provider's receipt of those funds.
5. That any transmission of partial funds by Attorney (or Patient if no Attorney) to Provider, even if stating "full and final satisfaction of Provider's lien" (or similar language), without Provider's prior written agreement to accept that reduced sum, shall not in any way be deemed an "accord and satisfaction" or otherwise limit Provider's entitlement to the full balance due and owing.
6. That any "med pay", PIP or similar insurance payment entitlement related to the Incident, is assigned to Provider. Attorney and Patient shall instruct the insurer to pay such entitlement directly to Provider, and if received by Attorney or Patient the recipient shall immediately send those med pay or PIP funds to Provider. Where "med pay" or PIP funds received by Provider fail to pay Provider's full bill, then Patient will remain responsible to pay the remaining balance still due and owing.
7. That if Patient's case or lawsuit does not result in a recovery sufficient to pay Provider's bill in full according to this Medical Lien, Patient agrees to remain fully liable for any remaining balance, and to promptly pay personally all remaining monies due and owing.
8. That Provider will be paid on the Medical Lien within thirty days of the first settlement monies having been received by Attorney or in the matter. Any sums owing to Provider shall accrue interest at the rate of ten percent (10%) per annum from the date treatment is concluded until the outstanding balance is fully paid.

9. That if Provider is required to retain an attorney to recover all or part of Provider's Medical Lien, that the prevailing party in any action arising from this Agreement shall be entitled to their reasonable attorney's fees and costs, including, but not limited to, any such fees and costs incurred in pre-filing collection efforts, negotiations or any Interpleader action involving the sums due. Venue and governing law for any disputes arising under this Medical Lien shall be in the county (venue) and State (law) where Provider is located.
10. That provider may sell or assign the rights to this lien to a third party without restriction. The cost of any such sale or assignment shall not reduce or be deemed to reduce the amount owed by Patient. Any purchaser or assignee shall have the same rights as Provider by law and under this Medical Lien.
11. That Patient directs Patient's Attorney (or Patient if no Attorney): (a) to keep Provider or Provider's designated agent informed in detail as to the progress of the underlying legal action and its potential resolution at least every three months until Provider is fully and finally paid; (b) to communicate to Provider in a timely fashion any issues with Provider's bill or any change in Attorney's representation of Patient; (c) prompt written notification of any impending resolution of any part of the lawsuit along with the amount of any settlement and a breakdown of all payouts made or intended from that settlement or case resolution if any discount is being sought; and (d) to provide any co-counsel or later substituted Attorney who will be representing Patient related to the Incident a copy of this Medical Lien with advisement that the co-counsel or new attorney is bound by this Medical Lien by virtue of the original attorney's signed agreement.
12. That if Patient remains, or becomes, unrepresented by Attorney, then Provider may at any time declare all amounts due under this Medical Lien all due and payable.

Patient has been advised that if Patient fails to follow the policies of Provider, the recommended treatment plan, or if Attorney does not protect Provider's Medical Lien interest or provide timely status updates of Patient's legal case upon the request of Provider or Provider's agent, then Provider is not required to await payment and instead may declare the entire balance due and payable and take all legal action necessary to collect that outstanding balance. Any delay by Provider in the enforcement of this Agreement will not be deemed a waiver of Provider's rights and remedies in any respect.

In the event that my case is rejected by the insurance company, I understand that I, and I alone, am fully and directly responsible for all medical bills incurred by me, as well as any attorney's fees and costs involved in the settlement of my account with, which shall include any attorney's fees incurred attempting to collect the monies owed or otherwise resolving this with you prior to filing formal legal action by AHCC. AHCC's legal fees are generally incurred at the rate of approximately $300 per hour.

PATIENT AGREEMENT:

Patient has read all the above, and understands and agrees to honor all terms and conditions of this Medical Lien contract. Patient has consulted with Attorney (if Attorney is retained), and should Patient retain new counsel, Patient agrees to provide that new counsel a copy of this Medical Lien prior to formal retention.

PATIENT NAME (PRINT): _____ PATIENT SIGNATURE: _____

PATIENT EMAIL: _____ DATE SIGNED: _____

ATTORNEY AGREEMENT:

Attorney agrees to honor all terms and conditions of this Medical Lien contract as stated above. Upon Attorney's full and timely compliance with the provisions of this Medical Lien as applies to Attorney, Attorney's fiduciary duties to Provider shall be deemed fully satisfied.

LAW FIRM NAME: _____

HANDLING ATTORNEY NAME (PRINT): _____

ATTORNEY SIGNATURE: _____ DATE SIGNED: _____

HANDLING ATTORNEY EMAIL: _____

PROVIDER AGREEMENT:

Provider, relying upon the representations made, and the agreement by both Patient and Attorney to all the above, agrees to accept and treat Patient, and to delay receiving payment, for services related to the injuries

sustained in this Incident under the conditions stated and no others. No modification to this Agreement, or any addendum or stamp, is valid unless I approve of those changes evidenced by my signature or initials next to each such change or on any attachment.
PROVIDER NAME (PRINT): _____
PROVIDER SIGNATURE: _____ DATE SIGNED: _____
Fully Signed Lien Faxed Back to Attorney (or Patient if no Attorney) On (DATE): _____