12104 State Line Rd, Leawood, KS 66209
Ph: 913.378.9810 Fax: 913.345.0958

Comprehensive Health History Forms

Patient Information

Patient Name:____________________ **DOB:**__________ **Gender:** ○M or ○F

Address: ____________________ **City:**__________ **State:**_____ **Zip Code:**________

Phone Number:____________ **Email:**____________________ **Last 4 of SSN**________

Occupation:____________ **Employer:**________________ **Phone:**____________

Marital Status: ○Single ○Married ○Widowed ○Divorced ○Separated **Spouse's Name:**________________

Spouse's Occupation:________________ **Spouse's Employer:**____________________

Emergency Contact: ________________ **Relationship:** ________ **Phone:**____________

What specific condition brought you into the office?:____________________________

Previous Care

What type of treatment have you received for this condition?____________________

Did it resolve the condition? ○Yes ○No

Primary Care Physician's Name:________________

Clinic Name:________________________

Clinic Phone Number:____________________

I allow my health progression to be shared with my primary care physician: ○Yes ○No

Lifestyle History

Check Your Exercise Level:
○Inactive
○Light Activity
○Moderate Activity
○Heavy Activity
○Vigorous Activity

Please check all that apply:
☐Tobacco ☐Alcohol ☐Coffee/Caffeine Beverages
Do you currently or have previously used recreational drugs?
○Yes ○No If yes, what types/method used (IV, inhaled, etc)________________________

Work Activity

Work Activity Level:
○Full-time ○Part-Time ○Homemaker ○Student ○Unemployed

If you are not working, it is due to the accident? ○ Yes ○ No

Have you had to decrease your work hours since the accident?
○ Yes ○ No If yes, how much?________________

Labor Activity:
○ Light ○ Moderate ○ Heavy ○ Sedentary

Work Activity Postures: (Select all that apply)
☐ Bending ☐ Climbing ☐ Kneeling ☐ Pulling
☐ Pushing ☐ Reaching ☐ Sitting ☐ Standing
☐ Twisting ☐ Walking ☐ Computer ☐ Repetitive

Medical History

Please list any previous car accidents or work injuries by approximate date. Did you completely recover?________________________

Please list any surgeries you have received by body part and approximate date. Did you completely recover?________________________

Please list current or previous medical problems not related to your accident (eg. Heart Disease, Diabetes, Cancer, High Blood Pressure, etc.)________________________

Please list current medications:____

Accident History

Date of Accident:______________________

Was the crash on the job? ○ Yes ○ No

Time of day: ○ Daylight ○ Dawn ○ Dusk ○ Dark

Road conditions: ○ Dry ○ Damp/Wet ○ Snow ○ Dark ○ Other_______

Intersection/Location of accident:________________________________
____

You were: ○ Driver ○ Front Seat Passenger ○ Left Rear Passenger ○ Right Rear Passenger ○ Middle Rear Passenger ○ Motorcycle Driver ○ Motorcycle Passenger ○ Bicycle ○ Pedestrian

Were you wearing a seatbelt? ○ Yes ○ No

Type of vehicle you were traveling in? (Year, Make, Model):
____

Your estimated speed at moment of impact?____________mph
○ Stopped ○ Slowing ○ Accelerating

The impact occurred on the (check all that apply):
○ Driver's Side ○ Passenger Side ○ Front ○ Rear

Which way were you facing at the time of impact?
○ Right ○ Left ○ Straight ahead

Estimated damage to the vehicle you were in:
○ Mild ○ Moderate ○ Major ○ Total Loss

Type of opposing vehicle involved in accident (Year, Make, Model):
____

Estimated speed of opposing vehicle involved in accident_______mph
○ Stopped ○ Slowing ○ Accelerating

Did airbags deploy? ○ Yes ○ No If yes, were you struck? ○ Yes ○ No

Did you hit your head? ○ Yes ○ No If yes, what did you hit your head against?____

Did other parts of your body strike the interior of the vehicle?
○ Yes ○ No If yes, explain:__________________________________

Did you experience a loss of consciousness ? ○ Yes ○ No
If yes, for about how long?__________________________________

Did police show up on scene? ○ Yes ○ No
Was there an accident report made? ○ Yes ○ No

Please explain in detail how the accident occurred:_________________
____
____

Were you treated by EMS on the scene? ○ Yes ○ No

Did you go to a hospital? ○ Yes ○ No
If yes, did you go the same day? ○ Yes ○ No
How did you get there? ○By Ambulance ○Drove Self ○By Someone Else
Did you receive imaging studies? ○ Yes ○ No If yes, please explain:
____
Other treatment provided:_____________________________________

Have you received treatment elsewhere due to this accident?
○ Yes ○ No If yes, please explain including names of doctors and where you received treatment.________________________________

Review of Symptoms and Past Medical History

Please mark "C" for current symptoms, "P" for past symptoms or leave blank if never.

Ears/Nose
- Ear Pain/Ear Infection ○C ○P
- Hay fever ○C ○P
- Ringing in Ears ○C ○P
- TMJ ○C ○P

Eyes/Vision
- Blindness ○C ○P
- Blurred/Double Vision ○C ○P
- Cataracts ○C ○P
- Glaucoma ○C ○P

Skin
- Eczema ○C ○P
- Hives ○C ○P
- Rashes ○C ○P

Cardiovascular
- Chest Pain ○C ○P
- Congestive Heart Failure ○C ○P
- Coronary Artery Disease ○C ○P
- Heart Murmur ○C ○P
- Pacemaker/Defibrillator ○C ○P
- Palpitations ○C ○P
- Swelling of Legs ○C ○P

Hematologic
- Anemia ○C ○P
- Easy Bleeding/Bruising ○C ○P
- Blood Clotting ○C ○P

Musculoskeletal
- Ankle/Foot Pain ○C ○P
- Arthritis ○C ○P
- Balance Problems ○C ○P
- Elbow Pain ○C ○P
- Fibromyalgia ○C ○P
- Hip Pain ○C ○P
- Joint Pain ○C ○P
- Knee Pain ○C ○P
- Low Back Pain ○C ○P
- Muscle Aches ○C ○P
- Muscle Cramping ○C ○P
- Muscle Stiffness(in a.m.) ○C ○P
- Neck Pain ○C ○P
- Pain Between Shoulder ○C ○P
- Pain Wakens You ○C ○P
- Shoulder Pain ○C ○P
- Weakness in Arms/Legs ○C ○P
- Wrist/Hand Pain ○C ○P

Gastrointestinal
- Abnormal Stool ○C ○P
- Constipation ○C ○P
- Crohn's Disease ○C ○P
- Diarrhea ○C ○P
- Reflux/Heartburn ○C ○P
- Nausea/Vomiting ○C ○P

Throat/Respiratory
- Asthma/ Wheezing ○C ○P
- Chronic Cough ○C ○P
- Chest Congestion ○C ○P
- Difficulty Swallowing ○C ○P
- Hoarseness ○C ○P
- Shortness of Breath ○C ○P
- Sore Throat ○C ○P

Endocrine
- Diabetes ○C ○P
- Fatigue/Drowsiness ○C ○P
- Goiter ○C ○P
- Hypo/Hyper Thyroid ○C ○P
- Weight Loss/Gain ○C ○P

Neurological
- Dizziness ○C ○P
- Facial/Limb Weakness ○C ○P
- Fainting ○C ○P
- Headaches ○C ○P
- Migraines ○C ○P
- Numbness/Tingling ○C ○P
- Seizures ○C ○P
- Sleep Disturbance ○C ○P
- Slurred Speech ○C ○P
- Stroke ○C ○P
- Tremor ○C ○P

Mental/Emotional
- Anxiety/Panic ○C ○P
- Clumsy ○C ○P
- Confusion ○C ○P
- Convulsions ○C ○P
- Depression ○C ○P
- Foggy Thinking ○C ○P
- Forgetfulness ○C ○P
- Hyperactive ○C ○P
- Insomnia ○C ○P
- Memory Loss ○C ○P
- Mood Swings/Irritability ○C ○P
- Poor Concentration ○C ○P
- Restless Leg Syndrome ○C ○P

Urinary
- Blood in Urine ○C ○P
- Burning or Pain ○C ○P
- Kidney Stones ○C ○P
- Urgency ○C ○P

Reproductive

Males Only:
- Erectile Dysfunction ○C ○P
- Impotence ○C ○P
- Prostate Enlargement ○C ○P

Females Only:
- Cramps ○C ○P
- Decreased Libido ○C ○P
- Infertility ○C ○P
- Heavy Bleeding ○C ○P
- Irregular Menstruation ○C ○P
- Ovarian Cysts ○C ○P
- Painful Periods ○C ○P

Current Complaints- Please list in order of severity

First Complaint:____

Onset: ○ Immediate ○ Within 24 hours ○ After 24 hours

What makes it better?____

What makes it worse?____

Quality of pain (Select all that apply)

☐ Burning ☐ Shooting ☐ Dull ☐ Ache ☐ Sharp ☐ Stabbing ☐ Numbness

Percentage of time the pain is noted from 0 to 100: ______________

Severity of pain on average from 0-10 (0 is no pain, 10 is the highest pain possible) ______________

Second Complaint:____

Onset: ○ Immediate ○ Within 24 hours ○ After 24 hours

What makes it better?____

What makes it worse?____

Quality of pain (Select all that apply)

☐ Burning ☐ Shooting ☐ Dull ☐ Ache ☐ Sharp ☐ Stabbing ☐ Numbness

Percentage of time the pain is noted from 0 to 100: ______________

Severity of pain on average from 0-10 (0 is no pain, 10 is the highest pain possible)______________

Third Complaint:____

Onset: ○ Immediate ○ Within 24 hours ○ After 24 hours

What makes it better?____

What makes it worse?____

Quality of pain (Select all that apply)

☐ Burning ☐ Shooting ☐ Dull ☐ Ache ☐ Sharp ☐ Stabbing ☐ Numbness

Percentage of time the pain is noted from 0 to 100: ______________

Severity of pain on average from 0-10 (0 is no pain, 10 is the highest pain possible) ______________

Fourth Complaint:____

Onset: ○ Immediate ○ Within 24 hours ○ After 24 hours

What makes it better?____

What makes it worse?____

Quality of pain (Select all that apply)

☐ Burning ☐ Shooting ☐ Dull ☐ Ache ☐ Sharp ☐ Stabbing ☐ Numbness

Percentage of time the pain is noted from 0 to 100: ______________

Severity of pain on average from 0-10 (0 is no pain, 10 is the highest pain possible) ______________

Fifth Complaint:____

Onset: ○ Immediate ○ Within 24 hours ○ After 24 hours

What makes it better?____

What makes it worse?____

Quality of pain (Select all that apply)

☐ Burning ☐ Shooting ☐ Dull ☐ Ache ☐ Sharp ☐ Stabbing ☐ Numbness

Percentage of time the pain is noted from 0 to 100: ______________

Severity of pain on average from 0-10 (0 is no pain, 10 is the highest pain possible) ______________

If you have additional complaints, please list:____

Patient Name:____**Date:**____________________

Rivermead Post Concussion Symptoms Questionnaire

After a head injury or accident, some people experience symptoms that can cause worry or nuisance. We would like to know if you now suffer any of the symptoms given below. Because many of these symptoms occur normally, we would like you to compare yourself now with before the accident. For each symptom listed below, please select the number that most closely represents your answer.

0= Not experienced at all
1= No more of a problem
2= A mild problem
3= A moderate problem
4= A severe problem

Compared with **before** the accident, do you **now** (i.e., over the last 24 hours) suffer from:

	Not Experienced	No more of a problem	Mild problem	Moderate problem	Severe problem
Headaches	○0	○1	○2	○3	○4
Feelings of dizziness	○0	○1	○2	○3	○4
Nausea and/or vomiting	○0	○1	○2	○3	○4
Noise sensitivity (easily upset by loud noise)	○0	○1	○2	○3	○4
Light sensitivity (easily upset by bright light)	○0	○1	○2	○3	○4
Sleep disturbance	○0	○1	○2	○3	○4
Fatigue, tiring more easily	○0	○1	○2	○3	○4
Being irritable, easily angered	○0	○1	○2	○3	○4
Feeling depressed or tearful	○0	○1	○2	○3	○4
Feeling frustrated or impatient	○0	○1	○2	○3	○4
Forgetfulness, poor memory	○0	○1	○2	○3	○4
Poor concentration	○0	○1	○2	○3	○4
Taking longer to think	○0	○1	○2	○3	○4
Blurred vision	○0	○1	○2	○3	○4
Double Vision	○0	○1	○2	○3	○4
Restlessness	○0	○1	○2	○3	○4

Are you experiencing any other difficulties? Please specify and rate as above.

1.	○0	○1	○2	○3	○4
2.	○0	○1	○2	○3	○4

http://www.maa.nsw.gov.au/default.aspx?MenuID=148

Patient Name:____ **Date:**________________________

Loss of Enjoyment of Sports, Hobbies, Travel, Daily Activities and School

Please select all that apply to your EXERCISE & SPORTS activities because of the accident:

☐ My exercise was affected by this crash
☐ I go to the gym and work out in pain
☐ I no longer go to the gym to work out
☐ I run but in pain
☐ I no longer run
☐ I take walks and have pain while walking
☐ I no longer take walks
☐ I used to make income at sports
☐ I am an amateur athlete
☐ I am a professional athlete
☐ I have gained_______ pounds since the accident
☐ I had to quit my ________________ team after the accident
☐ I had to quit my ________________ team after the accident
☐ I don't enjoy the sport of ________________ anymore
☐ I didn't enjoy the sport of ________________ for________weeks
☐ I don't enjoy the sport of ________________ anymore
☐ I didn't enjoy the sport of ________________ for________weeks
☐ ____

Please select all that apply to your HOBBY activities because of the accident:

☐ My hobbies were affected by the accident
☐ Hobby #1____
☐ I can't do hobby #1 anymore
☐ I do hobby #1 but in pain
☐ I have lost money from not doing hobby #1
☐ I didn't do hobby #1 for ________weeks
☐ Hobby #2____
☐ I can't do hobby #2 anymore
☐ I do hobby #2 but in pain
☐ I have lost money from not doing hobby #2
☐ I didn't do hobby #2 for ________weeks
☐ Hobby #3____
☐ I can't do hobby #3 anymore
☐ I do hobby #3 but in pain
☐ I have lost money from not doing hobby #3
☐ I didn't do hobby #3 for ________weeks
☐ Hobby #4____
☐ I can't do hobby #4 anymore
☐ I do hobby #4 but in pain
☐ I have lost money from not doing hobby #4
☐ I didn't do hobby #4 for ________weeks

Please select all that apply to your TRAVEL activities because of the accident:

☐ Business travel was affected by the crash
☐ Pleasure travel was affected by the crash
☐ I hurt driving in my own car
☐ I am in too much pain to drive
☐ I hurt when a passenger in a car
☐ I am in too much pain to sit in a car
☐ I have anxiety when I'm in a car
☐ I hurt when I'm on an airplane
☐ I am in too much pain to travel by plane
☐ Travel plan #1 ____
☐ I did not go on travel plan #1
☐ I went but did not enjoy travel plan #1 as much
☐ I went and the accident had no effect on travel plan #1
☐ Travel plan #2 ____
☐ I did not go on travel plan #2
☐ I went but did not enjoy travel plan #2 as much
☐ I went and the accident had no effect on travel plan #2
☐ I missed time with my family/friends because I can't travel

Please select all that apply to your SCHOOL & EDUCATION activities because of the accident:

☐ School was affected by the accident
☐ I am a student at ____
☐ I am in the ____year/grade
☐ I was enrolled (select one) ○ Full time ○ Part-time
☐ I am now enrolled (select one) ○ Full time ○ Part-time
☐ I had to take fewer classes because of the crash
☐ I missed ____________ days of school
☐ I had to drop out of school because of the crash
☐ My grades are lower since the crash
☐ I have pain carrying my school books
☐ I hurt sitting in class more than _______ minutes
☐ My neck hurts when I look down to read
☐ I don't learn as quickly as before the crash
☐ I don't learn things as well as before the crash
☐ I have difficulty concentrating in class
☐ It takes much longer to study/do my homework

Please select all the DAILY LIVING activities that cause you pain because of the accident:

☐ Dressing
☐ Putting on pants
☐ Putting on shoes
☐ Putting on shirt
☐ Tying my shoes
☐ Combing my hair
☐ Washing my hair
☐ Drying my hair
☐ Taking a shower
☐ Taking a bath
☐ Leaning forward
☐ Sleeping
☐ Laying in bed
☐ Going out w/friends
☐ Sitting at a restaurant
☐ Sitting on my favorite chair
☐ Shopping
☐ Driving to/from work
☐ Sitting in Church
☐ Playing with my children
☐ Caring for my children
☐ Drying w/a towel after showers
☐ Sitting in a movie theatre
☐ Life has become a chore to do normal things
☐ _________________________
☐ Stooping
☐ Squatting down
☐ Kneeling
☐ Brushing my teeth
☐ Riding in a car
☐ Opening a jar
☐ Lifting a pan when cooking
☐ Closing the trunk on my car
☐ Opening the garage door
☐ Using my home computer
☐ Climbing stairs
☐ Sexual activity
☐ Turning my head left or right
☐ Holding head up all day
☐ Watching TV
☐ Sitting and doing nothing
☐ Talking on the phone
☐ Reading
☐ Writing
☐ Opening doors
☐ Exercise
☐ It is depressing to live like this
☐ _________________________
☐ _________________________
☐ _________________________

Duties Performed Under Duress at Work and Home

Please select all that apply to your WORK activities because of the accident:

- ☐ I go to work but in pain
- ☐ I limit my work activities
- ☐ Bending at work hurts
- ☐ Stooping at work hurts
- ☐ Sitting at work hurts
- ☐ Using the computer at work hurts
- ☐ Pushing at work hurts
- ☐ Kneeling at work hurts
- ☐ I have lost status in my company
- ☐ I have lost job security
- ☐ I didn't get a promotion
- ☐ I don't enjoy work as much as before
- ☐ I doze off at work
- ☐ I take unpaid time off work to go to the doctor
- ☐ I daydream at work more than before
- ☐ I feel tired at work
- ☐ I work in pain because I have bills to pay
- ☐ I can't take time off because I would lose my job
- ☐ I keep working so I don't lose status at my company
- ☐ My business would fail if I took time off
- ☐ I believe in working even though I'm in pain
- ☐ I feel obligated to work even though I'm in pain
- ☐ My business would lose money if I took time off
- ☐ My work is not as good as it was before the accident
- ☐ I got a different job within the same company
- ☐ I got a different job in another company
- ☐ I make less money than before the accident
- ☐ I cannot do the same work/job as before the accident
- ☐ I can't concentrate as well at work
- ☐ I take paid time off to go to the doctor
- ☐ I make mistakes at work I didn't use to
- ☐ I hide my poor work performance from my boss
- ☐ ____
- ☐ ____

Please select all that apply to your HOME/DOMESTIC activities because of the accident:

- ☐ My house is not as clean now
- ☐ My yard is not as neat now
- ☐ My garden is not as productive now
- ☐ I do yardwork but do it in pain
- ☐ I cannot do my normal yardwork
- ☐ I do housework but do it in pain
- ☐ I cannot do my normal housework
- ☐ Doing laundry hurts me
- ☐ I cannot do laundry now
- ☐ Washing dishes hurts me
- ☐ I cannot vacuum now
- ☐ Cooking hurts me
- ☐ I cannot cook now
- ☐ Washing the car hurts me
- ☐ I cannot wash my car
- ☐ I cannot take time off because I care for children
- ☐ I have _________ children ages_________________________
- ☐ I had to hire a paid housekeeper
- ☐ I asked someone for unpaid housekeeping help
- ☐ I had to hire a paid gardener
- ☐ I asked someone for unpaid yardwork help
- ☐ Mowing the lawn hurts me
- ☐ I cannot mow the lawn
- ☐ Taking out the trash hurts me
- ☐ I cannot take out the trash
- ☐ I do not enjoy my gardening/yardwork like I used to
- ☐ I do not enjoy my housework like I used to
- ☐ Gardening hurts me
- ☐ I cannot do my gardening at all since the accident
- ☐ Others living with me do my share of the housework now
- ☐ Others living with me do my share of the yardwork now
- ☐ Others living with me do my share of the gardening now
- ☐ ____
- ☐ ____

Authorization for Release of Medical Records

I, the undersigned, hereby request and authorize the release of my personal health information to the physicians employed by Acute Spinal Rehab.

Purpose: _______ Continuation of Care

Treatment Dates: ___/___/___ to the present

Treating Facility: Acute Spinal Rehab

Treating Facility Address: ____
____

Stat:

Please send all records, including diagnostic studies such as X-rays, CT scans, MRI's, blood work, etc. This patient was seen at your facility for injuries sustained in an automobile accident on or about: ___/___/___

Authorization:

I certify that this request is made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time in writing by sending a letter to the facility Privacy Officer or their designee. I understand my revocation will not be effective to the extent that action has already been taken in reliance on it. This authorization will expire in 365 days. If I have authorized the disclosure of my health information to someone who is not legally required to keep it private, it may be re-disclosed and may no longer be protected.

Other Condition: A copy or facsimile of this form with my signature may be used with the same validity as the original.

Please send to the office fax number selected below:

- ○ Overland Park Fax # 913-685-2941
- ○ State Line Fax # 913-345-0958
- ○ Rainbow Fax # 913-677-8644

Name of Patient:________________________________ Patient's DOB:____________________

Date of Injury:________________________________Treatment Date:____________________

Patient's Signature:________________________________Date:____________________

Auto Accident Insurance/Attorney Information

DATE OF ACCIDENT:_______________________________

WHERE DID THE ACCIDENT HAPPEN?

Kansas: PIP $___________________ Missouri: Med Pay $___________________ Other State:___________________

AUTO ACCIDENT INSURANCE INFORMATION: YOUR INSURANCE INFORMATION
If you have not completed an application of benefits from your auto carrier, you must do so for charges to be covered.

Auto Insurance Carrier:____

Auto Insurance Phone #:____

Auto Insurance Mailing Address:____

Claim Adjuster's Name:____

Claim #:____

AUTO ACCIDENT INSURANCE INFORMATION: AT FAULT'S INSURANCE INFORMATION

Auto Insurance Carrier:____

Auto Insurance Phone #:____

Auto Insurance Mailing Address:____

Claim Adjuster's Name:____

Claim #:____

GENERAL HEALTH INSURANCE INFORMATION

Health Insurance Carrier:____

Health Insurance Phone #:____

Health Insurance Mailing Address:____

Member ID#:________________________________ Group #:________________________

Insured Person's Name:______________________________ Insured Person's DOB:__________________

ATTORNEY INFORMATION

Attorney Name:____

Attorney Phone #:____

Attorney Mailing Address:____

Contact Person at Attorney's Office:____

HIPAA Disclosure Acknowledgement

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your right concerning these records. Before we will begin any health care operation, we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your PHI, we encourage you to read the HIPAA NOTICE, this is available upon request at the front desk before signing this consent.

- The patient understands and agrees to Acute Spinal Rehab to use their PHI for the purpose of treatment, payment, healthcare, operations and coordination of care.
- The patient has the right to examine and obtain a copy for his or her own health records at any times and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Acute Spinal Rehab is not obligated to agree to those restrictions.
- A patient's written consent need only be obtained one time for all subsequent care given to the patient in this office.
- The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
- For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by Acute Spinal Rehab to assure that your records are not readily available to those who do not need them.
- Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
- If the patient refuses to sign this consent for purpose of treatment, payment, and healthcare operations, the physicians at Acute Spinal Rehab have the right to refuse to give care.

I have read and understand how my Patient Health Information (PHI) will be used and I agree to these policies and procedures.

Signature of Patient or Legal Guardian:____ **Date:**______________

Please list below the names of individuals we may discuss your claim with via phone, leave a voice message with, discuss anything pertaining to your claim, or scheduling appointments for you.

Name:______________________________ Phone #:______________ Relationship:______________

Name:______________________________ Phone #:______________ Relationship:______________

Informed Consent for X-rays

I, the undersigned being either the patient named above or the legally authorized representative of the patient named above, do hereby consent to the performance of diagnostic and imaging procedures at Acute Spinal Rehab on the terms and conditions more fully set out below. I understand that I have the right to be informed about the diagnostic imaging procedure being used so that I may make a decision whether or not to undergo the procedure.

- Consent to Imaging Procedure: Your attending physician believes it beneficial for you to undergo radiographic imaging to obtain additional information that may aid in diagnosing and treating your medical condition.
- It is important to notify the doctor/technologist if you have a heart pacemaker, brain aneurysm clips, and/or implanted metallic or electronic devices. Please inform the technologist if you are pregnant or think you may be pregnant.
- The benefit of this exam is to assist your physician with making a diagnosis.

By signing below, I hereby certify that I have fully read this consent, had it explained to me, or have had it read to me. I have been given an opportunity to ask questions about my condition, alternative forms of treatment, and procedures to be used, and the risks and hazards involved. I understand its contents and have sufficient information to give this informed consent.

Signature:____ **Date:**____________________

Consent to Evaluate and Adjust a Minor Child

I, ______________________ being the parent or legal guardian of ______________________ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Signature:____ **Date:**____________________

Consent for Treatment

I hereby authorize Acute Spinal Rehab and/or the providers thereof and whomever he/she may designate as his/her assistant to administer treatment as necessary for care. I understand that the practices of medicine and chiropractic care are not exact sciences and there are not guarantees of the results and that every individual may respond differently to a particular treatment regimen. I understand that there are certain risks associated with an examination or treatment and those risks have been presented and explained to me.

Signature:____ **Date:**____________________

Important Note to Patient:

Please note, we will be developing a treatment plan in order to facilitate a complete recovery from your injuries. But in order to do so, your assistance is needed. We ask that you make necessary arrangements to make appointments according to your treatment plan. If there is a compliance issue, we will need to make the attorney aware of this situation.

I have read and understand the above statement.

Signature:____ **Date:**____________________

Assignment and Lien Agreement

Preamble and Purpose: If you are presented with this Agreement, you have indicated to **ASR State Line** ("ASR") located at **12104 State Line Rd, Leawood KS 66209** that you have been involved in an injury causing event that You believe some other person or party is legally responsible for causing such injuries. The purpose of this Assignment & Lien Agreement is to provide You with immediate and ongoing healthcare treatment as is reasonably necessary to treat your injuries while providing You with sufficient time to obtain a monetary settlement or legal Judgment as a result of some other person or party causing Your injuries. In executing this Agreement, You are promising to ASR that You will directly or indirectly pay the outstanding balance of any charges for any healthcare treatment or services provided by ASR to You promptly after receiving the funds acquired from any settlement or judgment You may acquire.

Accordingly, I,____ (Name of Patient), agree to the following terms:

1. I agree to assign ASR the monetary proceeds from any recovery I receive as a result of my claim that some other person or party is responsible for causing my injuries and in an amount necessary to satisfy any outstanding unpaid balance I may have for past healthcare services and/or treatment provided by and through ASR.
2. I authorize ASR to seek full or partial payment for healthcare services provided by ASR from any *auto insurance carrier* who may be responsible for providing me with insurance benefits through Personal Injury Protection, Medical Payments coverage or some other medical insurance benefit derived from an *auto insurance carrier*. I further agree to cooperate with ASR in acquiring information related to *auto insurance benefits*, which may pay in full or in part for healthcare services and treatment provided by ASR.
3. In the event I have retained or later retain an attorney to represent my legal interests for the purpose of acquiring compensation for injuries caused by a person or party responsible for my injuries, I hereby authorize and direct my attorney to withhold monetary funds from any recovery I may acquire in settlement or through Judgment from any third party I claim is responsible for compensating me for an injury caused by some other person or party and direct my attorney to promptly provide these monetary funds to ASR for the express purpose of satisfying any outstanding and unpaid balance for healthcare treatment and/or services provided through ASR. In the event of recovery, I further authorize and direct any attorney I have retained to provide ASR with reasonable requests for information related to the amount of recovery I have acquired through a settlement or Judgment.
4. I authorize ASR to provide a copy of this Assignment & Lien Agreement to any attorney I may retain and any third party or insurance carrier who may be legally responsible for compensating me for treatment and services provided to me through ASR as a result of injuries caused by another person or party.
5. I understand and agree in executing this Agreement that ASR does not accept healthcare insurance benefits and ASR will be taking no action directly or indirectly to acquire payment for healthcare treatment and/or services provided by ASR from any healthcare insurance provider who may provide benefits to me.
6. I understand and agree that by executing this Agreement, my obligations for payment to ASR are not contingent upon my ability to make a successful monetary recovery from some other third party for injuries I believe to have been caused by some other person or party and further understand and agree that I shall be responsible to ASR for any outstanding unpaid balance that may exist for past healthcare treatment and services provided by ASR in the event I am unable to acquire a financial recovery that satisfies all or a portion of my unpaid balance after attempting to hold a third party legally responsible for injuries caused upon me.
7. I understand and agree that in an event I fail to comply with the terms and obligations set forth in this Agreement, ASR shall be entitled to seek legal recourse in a court of competent jurisdiction where it may seek recovery for any outstanding unpaid balance for healthcare treatment and services provided to me, interest at a rate of (18%) per annum accrued from the date of my breach of this Agreement and ASR shall be additionally entitled to seek any and all reasonable costs necessary to legally enforce this Agreement, including but not limited to reasonable attorney's fees.

In affixing my signature below, I am affirming that I have had the opportunity to read this Agreement, had the opportunity to ask questions as to the meaning of its terms to my satisfaction and agree to all of the terms set forth.

Total Due:___________________________

Patient Name:______________________________________ **Patient Signature:**____

Parent/Guardian Signature:____ **Date:**__________________

Doctor's Name:______________________________________ **Doctor's Signature:**____