CONCUSSION & WHIPLASH CLINIC

Live Well Health, PC • DBA: Concussion & Whiplash Clinic
7100 SW Hampton St. Suite 121, Tigard, OR 97223
Phone: 503-512-5359 • Fax: 971-249-8767
Office@ConcussionPDX.com

CONFIDENTIAL PATIENT INFORMATION

First Name:_____ Last Name:_____ DOB:_____ DOI:_____
Phone:_____ Email:_____ SSN:_____
Address:_____ Apt#_____ City:_____ State:_____ Zip:_____
Marital Status: Single / Married / Divorced / Widowed Spouse:_____
Emergency Contact:_____Relation:_____ Phone:_____
How did you locate our clinic?:_____ Referred by:_____

Claim Information
Cause: Auto Accident / Personal Injury / Work Injury / Sports Injury / Other:_____ State _____
Type of Claim: Auto Accident / Personal Injury / Work Injury / Sports Injury / Other:_____
Insurance Name:_____ Claim#_____
Adjuster:_____ Phone:_____ Fax:_____
Address:_____ City:_____ State:_____ Zip:_____

Employment Information (Work Injury Patients Only)
Employer:_____ Occupation:_____ FT / PT
Work Address:_____ City:_____ State:____ Zip:_____
Work Phone:_____ Ext:_____

Attorney Information
Attorney Name:_____ Email:_____Phone:_____ Ext:_____
Law office:_____ Phone:_____ Fax:_____

Authorizations:
A. I hereby authorize the release of any medical information necessary to process this claim and request payment of insurance benefits to either myself or to the party who accepts assignment. Additionally, I hereby authorize release of any medical information to any third party as I deem necessary for my medical benefit.
B. I authorize payment of any medical benefit from third parties for benefits submitted for my claim to be paid directly to this office. I authorize the direct payment to this office of any sum I now or hereafter owe to this office by my attorney, out of the proceeds of any settlement of my case and by any insurance company contractually obligated to make payment to me or you based upon the charges submitted for products and/or services rendered.
C. I Understand and agree that health and accident policies are an arrangement between the insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary billings, reports and forms to assist me in making collection from the insurance company, and that any amount will be authorized to be paid directly to this office will be credited to my account upon receipt.
D. However, I clearly understand and agree that all services and products rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for products or professional services rendered will be immediately due and payable.

Patient Name (Print)	Patient Signature	Date
Signature of Legal Representative/ Relationship		Date

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INCIDENT & INJURY INFORMATION

First Name:_____ Last Name:_____ DOB:_____ DOI:_____

Type of Injury: Auto Accident / Personal Injury / Work Injury / Sports Injury / Other:_____Time: _____AM/PM
Were others involved? Yes / No if yes Names: _____
Please describe the incident in your own words: _____
_____
Where did the incident occur? City: _____ State: _____

IF INJURY INVOLVED A VEHICLE (IF NOT SKIP TO HEAD POSITION)

Were you the: Driver / Passenger / Front Seat / Back Seat / Other: _____
Street: _____ City: _____ State: _____
Year and Model of your vehicle: _____ People in your vehicle: _____
Were you stopped? Yes / No. If no, your Est. speed: _____ Struck from the F / R / P / D

Year and model of other vehicle(s): _____
Were they stopped? Yes / No. If no, their Est. speed: _____ Struck from the F / R / P / D

Road Conditions? Wet / Dry Visibility? Good / Poor Wearing a seat belt? Yes / No With shoulder harness? Yes / No
Were you aware of the impending collision? Yes / No If yes, did you brace and how? _____
Did the air bags deploy? Yes / No Were the police notified? Yes / No If yes, was a report filed? Yes / No

HEAD POSITION

Your head position at injury? _____ Did you lose consciousness? Yes / No
If yes, how long?: _____ Please explain: _____
_____
Were you taken anywhere by ambulance or private party? Yes / No If yes, please explain any testing, medications and/or treatment you received: _____
_____
How did you feel:
Immediately following the incident? _____
_____
Later that day? _____
_____
The next day? _____
_____
The following days? _____
_____

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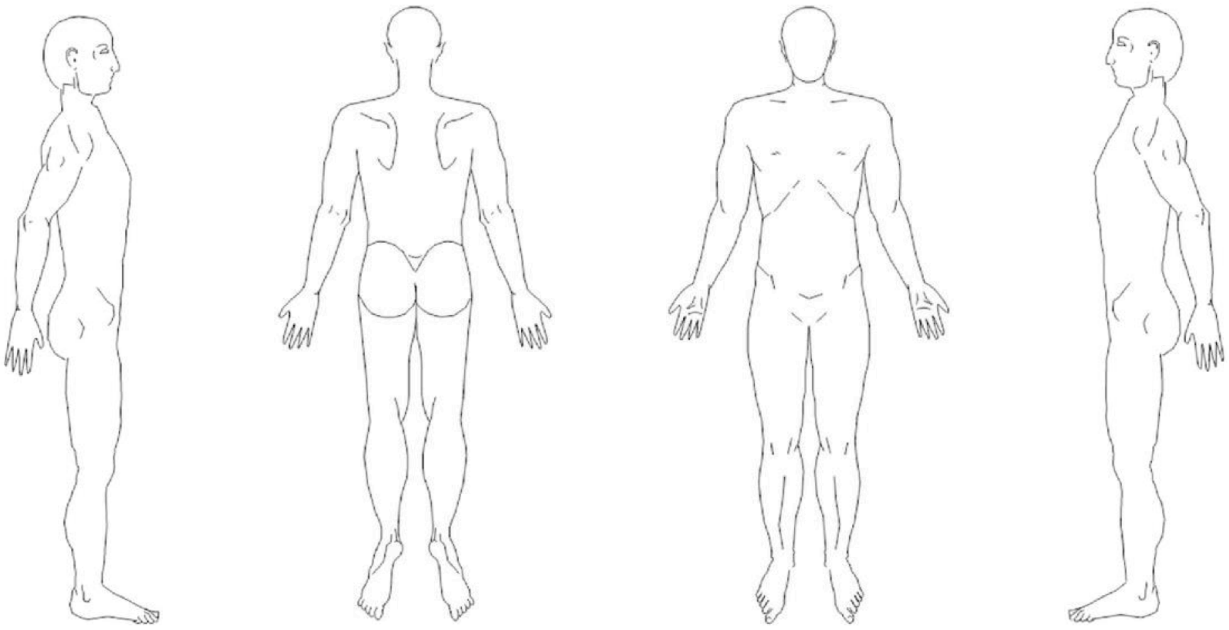
INCIDENT & INJURY INFORMATION

First Name:_____ Last Name:_____ DOB:_____ DOI:_____

Please mark all areas of pain on the diagrams below:



Please list your current health concerns related to your injuries in order of priority: _____

_____

Did your injuries occur while performing your job duties? Yes / No

If yes, please explain: _____

Has your condition impaired performing your job duties? Yes / No

If yes, please explain: _____

Have you lost time from work as a result of your injuries? Yes / No

If yes, please explain: _____

How do these conditions impair your daily activities? _____

How do these conditions impair your social activities? _____

What makes your condition better? _____

What makes your condition worse? _____

Anything else you would like to share? _____

Did you have any health complaints prior to your injuries? Yes / No

If yes, please explain: _____

Have you ever had your current injuries before this incident? Yes / No

If yes, please explain: _____

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INCIDENT & INJURY INFORMATION

First Name:_____ Last Name:_____ DOB:_____ DOI:_____

*If you have experienced any of the following conditions in the past, **please mark (P)** on the line provided.*
*If you are currently experiencing any of the following conditions, **please mark (C)** on the line provided.*

P	C	
		Heart Attack
		Stroke
		High BP
		Diabetes
		Cancer
		Arthritis
		Kidney Stones
		Gall bladder
		Prostate Problems
		Nausea/Vomiting
		Dizziness
		Headache
		Memory Loss
		Fainting
		Hearing Loss

P	C	
		Brain Fog
		Communication Challenges
		Ringing in Ears
		Asthma
		Diarrhea
		Constipation
		Trouble Swallowing
		Indigestion/Re-flux
		Abdominal Pain
		Difficulty W/ Urination
		Blood in Urine
		Blood in Stool
		Gout
		Muscle Pain
		Joint Replacement
		Joint Pain
		Unexplained Fatigue

P	C	
		Unexplained Weight Loss
		Unexplained Weight Gain
		Recent Fever/Sweats
		Chest Pain/Discomfort
		Palpitations
		Shortness of Breath
		Anxiety/Stress
		Sleep Problems
		Coughing/Wheezing
		Change in Vision
		Glaucoma
		Cold/Heat Intolerance
		Increased Thirst
		Light Intolerance
		Sensitivity to Noise
		Memory Challenges
		Over/Under Emotional

AUTHORIZATION

I certify that I have read and understand the above information to the best of my knowledge. The questions above have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize this office to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to this office benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Patient Name (Print) _____ Patient Signature _____ Date _____

OR

Signature of Legal Representative/ Relationship _____ Date _____

Post-Concussion Symptom Scale (PCSS)

Intermountain Health

Name: _____ DOB: _____ Date: _____

Instructions: For each item, indicate how much the symptom has bothered you over the past 2 days.

	Symptoms	None	Mild		Moderate		Severe	
Physical	1 Headache	0	1	2	3	4	5	6
	2 Nausea	0	1	2	3	4	5	6
	3 Vomiting	0	1	2	3	4	5	6
	4 Balance problems	0	1	2	3	4	5	6
	5 Dizziness	0	1	2	3	4	5	6
	6 Fatigue	0	1	2	3	4	5	6
	7 Sensitivity to light	0	1	2	3	4	5	6
	8 Sensitivity to noise	0	1	2	3	4	5	6
	9 Numbness/Tingling	0	1	2	3	4	5	6
Thinking	10 Feeling mentally foggy	0	1	2	3	4	5	6
	11 Feeling slowed down	0	1	2	3	4	5	6
	12 Difficulty concentrating	0	1	2	3	4	5	6
	13 Difficulty remembering	0	1	2	3	4	5	6
Sleep	14 Drowsiness	0	1	2	3	4	5	6
	15 Sleeping less than usual	0	1	2	3	4	5	6
	16 Sleeping more than usual	0	1	2	3	4	5	6
	17 Trouble falling asleep	0	1	2	3	4	5	6
Emotional	18 Irritability	0	1	2	3	4	5	6
	19 Sadness	0	1	2	3	4	5	6
	20 Nervousness	0	1	2	3	4	5	6
	21 Feeling more emotional	0	1	2	3	4	5	6
	TOTAL____/126							

Do you have any visual problems? ☐ Yes ☐ No

Do these symptoms worsen with:

- Physical Activity ☐ Yes ☐ No ☐ Not applicable
- Thinking/Cognitive Activity ☐ Yes ☐ No ☐ Not applicable

Over the past 2 days, my daily activity level has been ____% of normal.

If "YES" to any visual problems, further qualify with the Convergence Insufficiency Symptom Survey.

Permission from Wolters Kluwer; Lovell and Collins, *Journal of Head Trauma and Rehabilitation* 1998;13:9-26. Baseline levels should be taken and compared.

Perceived Stress Scale

A more precise measure of personal stress can be determined by using a variety of instruments that have been designed to help measure individual stress levels. The first of these is called the **Perceived Stress Scale**.

The Perceived Stress Scale (PSS) is a classic stress assessment instrument. The tool, while originally developed in 1983, remains a popular choice for helping us understand how different situations affect our feelings and our perceived stress. The questions in this scale ask about your feelings and thoughts during the last month. In each case, you will be asked to indicate how often you felt or thought a certain way. Although some of the questions are similar, there are differences between them and you should treat each one as a separate question. The best approach is to answer fairly quickly. That is, don't try to count up the number of times you felt a particular way; rather indicate the alternative that seems like a reasonable estimate.

For each question choose from the following alternatives:
0 - never 1 - almost never 2 - sometimes 3 - fairly often 4 - very often

_____ l. In the last month, how often have you been upset because of something that happened unexpectedly?

_____ 2. In the last month, how often have you felt that you were unable to control the important things in your life?

_____ 3. In the last month, how often have you felt nervous and stressed?

_____ 4. In the last month, how often have you felt confident about your ability to handle your personal problems?

_____ 5. In the last month, how often have you felt that things were going your way?

_____ 6. In the last month, how often have you found that you could not cope with all the things that you had to do?

_____ 7. In the last month, how often have you been able to control irritations in your life?

_____ 8. In the last month, how often have you felt that you were on top of things?

_____ 9. In the last month, how often have you been angered because of things that happened that were outside of your control?

_____ 10. In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?

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PATIENT QUESTIONNAIRE

First Name:_____ Last Name:_____ DOB:_____ DOI:_____

1. Place a check on the line in the first (1st) column if you had any of these **symptoms before the collision.**
2. Place a check on the line in the second (2nd) column if you had any of these **symptoms after the collision**.
3. Place a check on the line in the third (3rd) column if you are experiencing any of these **symptoms today.**

Please leave the last column blank (for office use only)

Head, Face, and Neck Pain	Before DOI	After DOI	Today	OFFICE ONLY Today 0/10
Headache – Right / Left				
Face – Right / Left				
Upper Neck – Right / Left / Mid-line				
Lower Neck – Right / Left / Mid-line				

Back Pain	Before DOI	After DOI	Today	Today 0/10
Upper Back – Right / Left / Mid-line				
Middle Back – Right / Left / Mid-line				
Lower Back – Right / Left / Mid-line				
Pelvis – Right / Left / Mid-line				

Upper Body Pain	Before DOI	After DOI	Today	Today 0/10
Shoulders - Right / Left / Front / Back				
Arms - Right / Left				
Hands - Right / Left				
Fingers - Right / Left				

Lower Body Pain	Before DOI	After DOI	Today	Today 0/10
Hips - Right / Left				
Thighs - Right / Left				
Legs - Right / Left				
Feet - Right / Left				

AUTHORIZATION

I certify that I have read and understand the above information, and is correct and accurate to the best of my knowledge.

Patient Name (Print) _____ Patient Signature _____ Date _____

OR

Signature of Legal Representative/ Relationship _____ Date _____

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PATIENT ACKNOWLEDGMENT OF HIPAA NOTICE

Notice to Patient:
We are required to offer you a copy of our HIPAA notice which states how we may use and/or disclose your health information. Our HIPAA notice and office policies contain information regarding payment, health insurance, collections, and other important information.

Patient Acknowledgement:
I acknowledge and agree to this office's HIPAA notice. I acknowledge that I have reviewed the HIPAA notice and have the right to obtain a paper copy of the HIPAA notice. I acknowledge that I may refuse to sign this acknowledgement if I wish.

_____
Patient Printed Name

_____
Patient Signature or legal representative

_____
If legal representative, state relationship

_____
Date

FOR OFFICE USE ONLY:
We have made every effort to obtain the written acknowledgement of receipt of our HIPAA notice from this patient, but it could not be obtained because:
____ The patient refused to sign
____ We were not able to communicate with this patient
____ Due to an emergency situation it was not possible to obtain a signature
____ Other (please provide detains):
_____

_____
Name of patient

_____
Name of staff member

_____
Signature of staff member

_____
Date

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First Name:_____ Last Name:_____ DOB:_____ DOI:_____

Appointment Reminder Authorization Form

Please indicate below which way you would like to be reminded:

☐ **EMAIL:** I authorize Live Well Health, PC. to send Appointment Reminders electronically via email to the following email address.

☐ **TEXT MESSAGE:** I authorize Live Well Health, PC. to send Appointment Reminders electronically via text message to my mobile phone. I understand that this service is offered free of charge. However, standard text messaging rates from my mobile carrier may apply. Please activate text message reminders for the patient/mobile phone number.

☐ **VOICE MESSAGE:** I authorize Live Well Health, PC. to send Appointment Reminders via voice messaging. If I am unavailable to answer the telephone, I give Live Well Health, PC permission to leave a message on my answering machine or with the person answering the telephone.

EMAIL ADDRESS (please print clearly): _____ MOBILE#: _____

Patient Name (Print)	Patient Signature	Date

Appointment Cancellation Policy

Live Well Health P.C. has instituted the following Appointment Cancellation Policy.

- Please provide our office 24-hour notice in the event that you need to reschedule your appointment. A message can always be left to avoid a cancellation fee being charged.
- **A "No-Show", "No-Call" or "Missed Appointment", without proper 24-hour notification, may be assessed a $75 fee.**
- If you are 20 or more minutes late for your appointment, the appointment may be canceled, rescheduled, or considered a "Missed Appointment" and may be assessed a $75 fee.
- These fees are not billable to your insurance and **will be charged to your account.**
- As a courtesy, we have email and text reminders for appointments, one to two days in advance. Please note, if a reminder call or message is not received, the cancellation policy remains in effect.
- Repeated missed appointments may result in termination of the clinician/client relationship.

We understand that there may be times when an unforeseen emergency occurs, and you may not be able to keep your scheduled appointment. *If you should experience extenuating circumstances, please contact our office as we may be able to waive the "No Show" fee (for a one-time exception).*

I, _____ have read and understand the Appointment Cancellation Policy and I acknowledge its terms. I also understand and agree that such terms may be amended from time-to-time by the clinic.

Patient Name (Print)	Patient Signature	Date

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Informed Consent Agreement for Laser Therapy

I understand that Laser Therapy is a safe and noninvasive treatment cleared by the FDA to emit energy on the infrared spectrum to provide topical healing. I further understand that there is no promise or guarantee regarding the results of the treatment, and that to achieve maximum clinical results, I may need multiple treatments. I understand that mild adverse reactions with normal treatment protocols may occur. Some patients may report increased pain after the initial treatment or within 24 hours. I am aware of the following safety requirements.

EYE SAFETY: I understand that Class IV Therapy Lasers emit both visible and invisible radiation. Protective eye-wear is necessary at all times during the treatment. I will not remove the Safety Goggles until the administrator of the laser has turned off the laser treatment and provided notification that it is safe. I will remove all reflective objects, such as rings, metal watchbands, and jewelry prior to treatment with the laser, to avoid reflective surfaces. I will never look directly into the end of the laser therapy hand piece.

CONTRADICTIONS: I have informed the physician or assistant that I may have or use one of the following:	**PRECAUTIONS:** Do not treat the area directly over and within a 10" radius of the following:
o Anticoagulants o Autoimmune disorders o Encephalopathy o Epilepsy (mild) o Multiple sclerosis o Photosensitizing medications o Renal failure (severe) o Systemic infections lupus (severe)	o Pacemaker o Ununited epiphyseal plate o Ununited fontanelles o Tattoos – the tattoo area can be treated, but treatment technique must be adjusted due to the high absorption rate of the tattoo ink o Steroid injections – area can be treated after 72 hours of the injection.

I KNOWINGLY AND WILLINGLY CONSENT TO TREATMENT WITH THE FULL UNDERSTANDING AND DISCLOSURE OF RISKS ASSOCIATED WITH RECEIVING CARE. I UNDERSTAND THIS CONSENT FORM APPLIES TO SUBSEQUENT VISITS AND TREATMENTS. I CONFIRM ALL MY QUESTIONS WERE ANSWERED TO MY SATISFACTION.

Patient Name (Print) _____ Patient Signature _____ Date _____

Informed Consent Agreement for Acupuncture

Rocco Manziano, L.A.c is licensed by the Oregon State Board of Medical Examiners and uses only stainless-steel, sterilized, disposable needles to ensure safety. Certain adverse effects may result from treatment; which can include, but are not limited to: slight bleeding and bruising or soreness at the insertion site. I understand that acupuncture and other natural health approaches provided by Rocco Manziano, L.A.c uses methods to reduce stress and increase the body's self-healing abilities. Rocco Manziano, L.A.c cannot say that he can diagnose, treat, prevent, or cure any diseases; and cannot make any guarantees as how your body will respond to his healing methods.

I understand that if I am under the care of a Physician for any ailment(s) or condition(s), that I will continue my care exactly as prescribed until advised differently by my Physician. This permission form applies to all subsequent visits and consultations.

I KNOWINGLY AND WILLINGLY CONSENT TO TREATMENT WITH THE FULL UNDERSTANDING AND DISCLOSURE OF RISKS ASSOCIATED WITH RECEIVING CARE. I UNDERSTAND THIS CONSENT FORM APPLIES TO SUBSEQUENT VISITS AND TREATMENTS. I CONFIRM ALL MY QUESTIONS WERE ANSWERED TO MY SATISFACTION.

Patient Name (Print) _____ Patient Signature _____ Date _____

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Informed Consent Agreement for Evaluation and Therapeutic Care

Evaluation and therapeutic care, including chiropractic, functional neurology, physical medicine, nutrition, and massage, like all forms of healthcare, while offering considerable benefit may also provide some level of risk. This level of risk is often very minimal, yet in rare cases injury has been associated with evaluation and therapeutic care. Complications that have been reported secondary to evaluation and therapeutic care include skin, muscle and/or nerve irritations, and/or injury. One of the rarest complications associated with chiropractic care, in particular, occurring at a rate of between one instance per 1 million, to one instance per 2 million cervical spine (neck) adjustments may be vertebral artery injury that could lead to a stroke. Prior to receiving evaluation and therapeutic care, a health history and a physical examination will be completed. These procedures are performed to assess your specific conditions, your brain and spine health, and your overall health. These procedures will assist us in determining if any care provided at Live Well Health, PC, is needed, or if any further examinations or studies are needed. In addition, they will help us to determine if any reason to modify your care or provide you with a referral to another healthcare provider. All relevant findings will be reported to you along with a care plan prior to beginning care.

I KNOWINGLY AND WILLINGLY CONSENT TO TREATMENT WITH THE FULL UNDERSTANDING AND DISCLOSURE OF RISKS ASSOCIATED WITH RECEIVING CARE. I UNDERSTAND THIS CONSENT FORM APPLIES TO SUBSEQUENT VISITS AND TREATMENTS. I CONFIRM ALL MY QUESTIONS WERE ANSWERED TO MY SATISFACTION.

Patient Name (Print) _____ Patient Signature _____ Date _____

Informed Consent Agreement for the Therapies Below.

The therapies listed below are not intended to diagnose, treat, cure, or prevent any medical condition or disease.

	PEMF (Pulsed Electro-Magnetic Frequency) Therapy		**Far Infrared Therapy**
	Hot Stone Therapy		**Photon Light Therapy**
	Negative Ion Therapy		**Teeter Inversion Table**
	Transcutaneuos Electrical Nerve Stimulation		

I understand certain contraindications may preclude me from receiving PEMF/hot stone/negative ion/far infrared mat treatments; including vascular disease, deep vein thrombosis, multiple sclerosis, epilepsy, medications causing light sensitivity, open wounds, pregnancy, nursing, having a pacemaker, and/or thyroid conditions. I further understand if I have any of these medical issues or other preexisting conditions such as heart disease, hypertension, or any other serious medical condition I will consult with my primary doctor and may require a doctor's release before I assume any risk involved.

I KNOWINGLY AND WILLINGLY CONSENT TO TREATMENT WITH THE FULL UNDERSTANDING AND DISCLOSURE OF RISKS ASSOCIATED WITH RECEIVING CARE. I UNDERSTAND THIS CONSENT FORM APPLIES TO SUBSEQUENT VISITS AND TREATMENTS. I CONFIRM ALL MY QUESTIONS WERE ANSWERED TO MY SATISFACTION.

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PEMF (Pulsed Electro-Magnetic Frequency) Therapy

PEMF therapy stimulates the body's cells to support your ability to recover from pain or injury. These are low level frequency waves. Different from the harmful ones found with an x-ray machines. When the cells are injured, they lose their ability to move ions because they no longer have a magnetic charge. PEMF therapy helps restore the electromagnetic charge in those cells so they can continue to support the body's recovery process. This therapy is conducted through a heating mat and pillow, in which the user would lay on top of to receive the benefits. Additionally, we also have a shoulder wrap available.

Hot Stone Therapy

This form of massage therapy used to relax the body using flat heated stones. The hot stones activate the parasympathetic nervous system which helps calm any stress, anxiety, and pain. They also promote better sleep. These stones are built into the PEMF mat, and the benefits are received simply by laying on the mat.

Negative Ion Therapy

Negative ions are naturally emitted from the gemstones in the PEMF mat, pillow, and shoulder wrap. Negative ions are molecules in the air that negatively charged electrons. These ions are responsible for keeping the air clean of various allergens, such as mold or pollen found in the air. Negative ions have been shown in research to improve mood and increase oxygen flow to the brain. A person will receive these benefits simply by laying on the PEMF mat, pillow, using the shoulder wrap, and/or the infrared pad.

Far Infrared Therapy

This is another form of light therapy that is naturally expelled from the advanced heating system as well as the hot stone layer of the PEMF mat, pillow, and shoulder wrap. These rays of invisible light penetrate deep into the body and promotes the alleviation of pain, improved blood circulation, reduction of inflammation in joints, and the protection of oxidative stress. The higher the temperature, the greater the level of far-infrared rays. The user receives these benefits simply by laying on the mat, pillow, or by wearing the shoulder wrap. We also have a separate Infrared pad and pillow to include along with the PEMF mat to boost overall benefits received.

Photon Light Therapy

Photon light therapy is an effective therapy that goes deep into the cells to help repair them at the source of their energy: the mitochondria. By boosting the functions of the mitochondria, it empowers the cell to become more energized and efficient in supporting the body's recovery process. This can help reduce pain, inflammation and improve skin complexion. This therapy is built into the PEMF pillow, and the benefits are received simply by exposing the back of the neck to the light.

Teeter Table

Inversion therapy is a technique where you are suspended upside down to stretch the spine and relieve back pain. For these reasons it may be beneficial for people with Chronic lower back pain, poor circulation, sciatica, and scoliosis. Inversion therapy is deemed unsafe for people with certain conditions. The upside-down position increases blood pressure and decreases your heart rate. It also puts significant pressure on your eyeballs. Your doctor may not recommend inversion exercise if you have certain conditions including bone and joint disorders, cardiovascular disorders, or diseases and infections.

Transcutaneuos Electrical Nerve Stimulation

The Stimpod NMS460 is a Transcutaneuos Electrical Nerve Stimulation device used for symptomatic relief and management of chronic intractable pain and/or as an adjunctive treatment in the management of post-surgical pain, post traumatic acute pain problems, as well as an adjunct for pain control due to rehabilitation.

Contradictions are; known neurological disorders, Patients with a cardiac pacemaker, implanted defibrillator, or other implanted metallic or electronic device. Not to be used on patients whose pain syndromes are undiagnosed.

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AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS

Patient Name: _____ Date of Birth: _____
(maiden name/other names used): _____

I hereby request and authorize:

Live Well Health, PC · PO Box 2415 · Wilsonville, OR 97070
503-855-4465 Phone 971-249-8767 fax

☐ To Disclose Information to: ☐ To Receive Information from:

Name/Provider: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Ext: _____ Fax: _____

Name/Provider: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Ext: _____ Fax: _____

Name/Provider: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Ext: _____ Fax: _____

Attorney Name:_____ Email:_____Phone:_____ Ext:_____
Law office:_____ Phone:_____ Fax:_____

Information to be disclosed includes copies of:

- ☐ Entire Record
- ☐ X-Ray Reports
- ☐ Daily Chart Notes
- ☐ Reports
- ☐ CT Scan Reports
- ☐ MRI / Reports
- ☐ Physical Exam Forms
- ☐ Other, specify _____

This authorization will be in effect for six months after the date signed, unless canceled in writing. I understand that the cancellation will have no effect on information released prior to receiving the cancellation. A copy of this authorization is as valid as the original.

_____ _____ _____
Patient Name (Print) Patient Signature Date

OR

_____ _____
Signature of Legal Representative/ Relationship Date

If signing for a minor patient, I hereby state that my parental rights have not been revoked by a court of law. Notice to recipient of information: This information has been disclosed to you from confidential records, which are protected by law. Unless you have further authorization, laws may prohibit you from making any further disclosures of this information without the specific written consent of the patient of legal representative.

CONCUSSION & WHIPLASH CLINIC

Live Well Health, PC • DBA: Concussion & Whiplash Clinic
7100 SW Hampton St. Suite 121, Tigard, OR 97223
Phone: 503-512-5359 • Fax: 971-249-8767
Office@ConcussionPDX.com

IRREVOCABLE DOCTOR'S LIEN AND ASSIGNMENT OF RIGHT TO RECOVERY

In consideration and exchange for not having to pay immediately the debt owed and in consideration for receiving future care at or by the clinic and providers whose letterhead this document is printed (hereinafter 'Concussion & Whiplash Clinic'). I, the undersigned, hereby grant, sell, bargain, assign, and convey to Concussion & Whiplash Clinic a legal and equitable interest in any and all causes of action or rights of recovery I may have arising out of that certain accident or trauma-producing event which occurred on or about the _____day of _____, 20_____ to the full extent of the cost of treatment provided or to be provided to me by Concussion & Whiplash Clinic.

I hereby authorize and direct my attorney(s) to hold in trust, and to pay directly to Concussion & Whiplash Clinic such sums as may be due and owing Concussion & Whiplash Clinic for treatment and other professional services rendered me both by reason of this accident and by reason of any other bills that are due to Concussion & Whiplash Clinic and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately pay and protect Concussion & Whiplash Clinic. I hereby further give, grant, assign, and convey a legally enforceable interest and lien on my case to Concussion & Whiplash Clinic against any and all proceeds of any and all causes of action, settlements, judgments, or verdicts by which I may be paid to or through my attorney, or myself, as the result of the injuries or conditions for which I have been treated by Concussion & Whiplash Clinic.

I fully understand that I am directly and fully responsible to Concussion & Whiplash Clinic for all bills incurred for services rendered to me, and that this agreement is made solely for Concussion & Whiplash Clinic's additional protection and in consideration for Concussion & Whiplash Clinic waiting for payment. I further understand that payment for services rendered by Concussion & Whiplash Clinic is not contingent on any settlement, judgment, or verdict for which I may eventually recover. I am personally responsible for my bills regardless of the outcome of any legal claim or case.

I fully understand if my attorney(s) does/do not protect Concussion & Whiplash Clinic's interest, Concussion & Whiplash Clinic may require me to make payments on a current basis. Concussion & Whiplash Clinic may also bring a cause of action against my attorney(s) for failing to honor this binding and irrevocable agreement between Concussion & Whiplash Clinic and me.

I further understand and agree that Concussion & Whiplash Clinic is not responsible for paying any of my attorney's fees and Concussion & Whiplash Clinic does not agree to pay my attorney(s) or any attorney(s) fees for honoring this agreement between me and Concussion & Whiplash Clinic.

"I HAVE READ AND FULLY UNDERSTAND THIS DOCUMENT, AND I AM VOLUNTARILY SIGNING THIS DOCUMENT. I AM DIRECTING MY ATTORNEY(S) TO PROTECT CONCUSSION & WHIPLASH CLINIC'S INTEREST AT THE TIME OF SETTLEMENT, AND I AM ASSIGNING AND CONVEYING CERTAIN LEGAL RIGHTS OVER TO CONCUSSION & WHIPLASH CLINIC. I ALSO KNOW THAT I MAY NOT REVOKE THIS AGREEMENT AT ANY TIME WITHOUT PRIOR WRITTEN AUTHORIZATION FROM CONCUSSION & WHIPLASH CLINIC. I UNDERSTAND THAT, AMONG OTHER THINGS, THIS IS A BINDING AND ENFORCEABLE CONTRACT, ASSIGNMENT, CONVEYANCE, AND LIEN."

Patient Name (Print)	Patient Signature	Date

OR

Signature of Legal Representative/ Relationship	Date