

PERSONAL INJURY PATIENT HISTORY

NAME _____ DATE _____ FILE# _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE _____ WORK PHONE _____

DATE OF BIRTH _____ AGE _____ MARITAL STATUS _____

SOCIAL SECURITY _____ SPOUSE'S FIRST NAME _____

In case of an emergency whom should we notify? _____
Address _____ Phone _____ Relationship _____

INSURANCE INFORMATION *** (Patients Auto Insurance Information) ***

COMPANY NAME _____ POLICY # _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

ADJUSTER'S NAME _____ PHONE _____

INSURED'S AUTO INSURANCE (Driver/ owner of car you were in, if not yourself)

NAME OF INSURED _____ PHONE _____

COMPANY NAME _____ POLICY _____

ADJUSTER'S NAME _____ PHONE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

INSURED'S HEALTH INSURANCE

COMPANY NAME _____ ID# _____

PHONE _____ GROUP # _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

Did you bring a copy of the police report? YES NO N/A

Did you bring all emergency room and other doctor's medical records regarding the accident? YES NO N/A

DATE OF ACCIDENT _____ TIME _____ AM/PM

Where were you seated? Driver's seat, Passenger front seat,
 Middle front seat, Right back seat, Middle back seat, Left back seat

Who owns the car? _____ Make/ Model of car _____

What approximate damage was done to the car you were in? \$ _____

Road conditions at the time of the accident: Icy, Wet, Clear, Dark

Your car: Hit another car, or Was hit in the R or L, Rear, Front, Side

Type of accident: Head on collision, Broadside (T-bone), Rearended,
(Check one) Front impact- rearended car in front of you, Non collision,
 Other _____

Explain in detail how your accident occurred: _____

Were you prewarned the accident was about to happen? YES or NO

Did you brace for the impact? YES or NO

Were you wearing a seatbelt/ shoulder harness? YES or NO

Did your car have headrests? YES or NO If YES, what position were they in?
 Top of headrest even with the bottom of your head
 top of the headrest even with the top of your head
 Top of the headrest even with the middle of the back

Was your car breaking? YES or NO

HEAD/ BODY POSITION AT THE TIME OF THE ACCIDENT: Head turned L or R
 Head looking back, Head straight forward, Body straight in a sitting position,
 Body rotated: L or R

Were your hands on the steering wheel at the time of the accident? YES or NO

Was your car pushed forward as a result of the accident? YES or NO

If YES, estimate distance _____

Did your car hit anything else after the initial impact? _____

Indicate if your body part(left column) hit anything in the car (right column)

Draw lines matching the left side with the right side

Head	Windshield
Face	Steering wheel
Shoulder	Side door
Neck	Dashboard
Chest	Car frame
Hip	Another occupant
Knee	Seat
Foot	Seatbelt
Hands	Sun visor

Was there any glass broken or shattered? YES or NO

CHECK if any of the following vehicle parts broke, bent or were damaged in the car:
 Windshield, Seat frame, Mirror, Steering wheel, Dash,
 Side / rear window, Other _____

Was the car towed from the accident? YES or NO

Was the car drivable? YES or NO

As a result of the accident were you: Rendered unconscious, Dazed,

Circumstances vague, Shaken but could function

Other _____

Could you move all parts of your body? YES or NO if YES, what parts could you not move and why? _____

Were you able to get out of the car and walk unaided? YES or NO if NO, why not? _____

Did you receive any bleeding cuts or bruises? YES or NO if YES, where? _____

Immediately after the accident how did you feel? _____

WORK STATUS:

Occupation: _____ Employer: _____

How long have you been at your present job? _____

Have you missed any work as a result of the accident? *YES or NO*
if *YES*, how long _____

Have you been able to work since the accident? *YES or NO*

PAST HISTORY:

Have you ever had any injuries and/ or complaints similar to your current pain? _____

If *YES*, where? _____

When? _____ Why? _____

Have you ever been in a car accident before? *YES or NO* if *YES*, when? _____
Any injuries? _____

Are you currently being treated by another doctor for any other health conditions? *YES or NO* if *YES*, provide the doctor's names and condition _____

Current medication _____

SOCIAL HISTORY:

[] Smoke- packs/ day _____ , how long? _____ [] Alcohol

Exercise level: (circle one) Light Medium Heavy

Type of exercise _____

FAMILY HISTORY: _____

SURGICAL HISTORY: _____

Primary care physician's name: _____

Where were you taken after the accident? _____

By ambulance? *YES or NO*, Which hospital _____

Were you admitted? *YES or NO*

Were x-rays or any other tests performed? _____

What treatment did you receive? _____

Did anything make you feel better? _____

Over the next 24 hours, how did you feel? _____

Did you receive any other medical treatment after the accident? *YES or NO* if *YES*, by whom? _____

Did this treatment help? _____

Symptoms after the accident: (check as many as applicable)

- | | |
|---|---|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Irritability |
| <input type="checkbox"/> Neck pain/ stiffness | <input type="checkbox"/> Impaired concentration |
| <input type="checkbox"/> Arm pain numbness/ tingling | <input type="checkbox"/> Confusion |
| <input type="checkbox"/> Mid back pain | <input type="checkbox"/> Throat pain |
| <input type="checkbox"/> Low back pain | <input type="checkbox"/> Painful swallowing |
| <input type="checkbox"/> Leg pain/ numbness/ tingling | <input type="checkbox"/> Poor sleep |
| <input type="checkbox"/> Eyes sensitive to light | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Pain behind the eyes | <input type="checkbox"/> Chest pain |
| <input type="checkbox"/> Weakness in arms / legs | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Blurry vision |
| <input type="checkbox"/> Ringing in the ears | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Loss of memory | <input type="checkbox"/> Jaw pain |
| <input type="checkbox"/> Fatigue | |

PAIN DRAWING:

Circle the Severity of your pain on the line below:

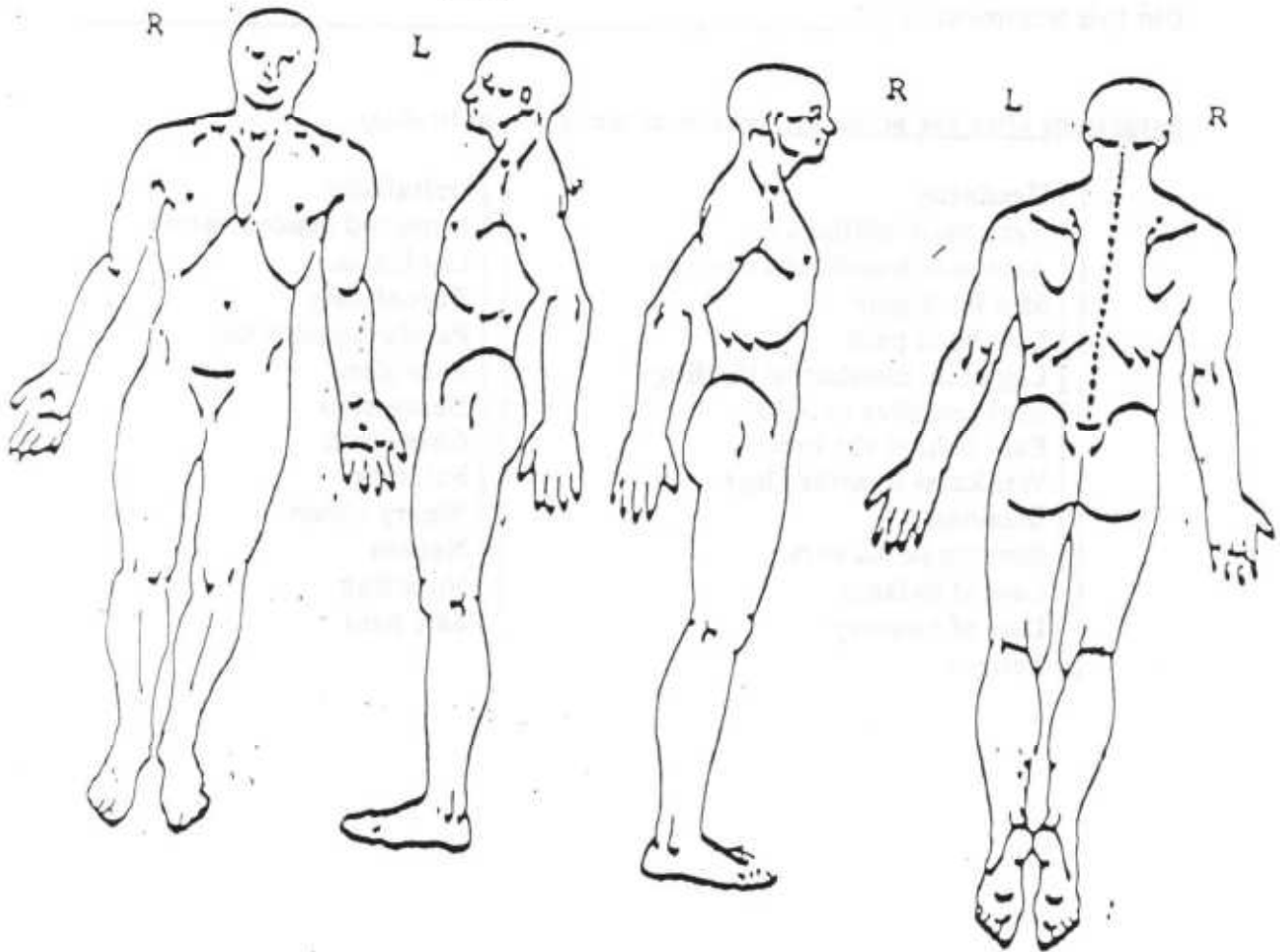
0-1-2-3-4-5-6-7-8-9-10

(No pain)

(Extreme pain)

Mark the location of your pain on the body outlines below using the following Letters:

A=Ache B=Burning N=Numbness P=Pins and Needles S=Stabbing X=Other(Specify)



Oswestry Disability Index **LOW BACK**

Section 1 - Pain Intensity

- 0 I have no pain at the moment.
- 1 The pain is very mild at the moment.
- 2 The pain is moderate at the moment.
- 3 The pain is fairly severe at the moment.
- 4 The pain is very severe at the moment.
- 5 The pain is the worst imaginable at the moment.

Section 2 - Personal Care (washing, dressing, etc.)

- 0 I can look after myself normally but it is very painful.
- 1 I can look after myself normally but it is very painful.
- 2 It is painful to look after myself and I am slow and careful.
- 3 I need some help but manage most of my personal care.
- 4 I need help every day in most aspects of my personal care.
- 5 I need help every day in most aspects of self-care.
- 6 I do not get dressed, wash with difficulty, and stay in bed.

Section 3 - Lifting

- 0 I can lift heavy weights without extra pain.
- 1 I can lift heavy weights but it gives extra pain.
- 2 Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (i.e. on a table).
- 3 Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- 4 I can lift only very light weights.
- 5 I cannot lift or carry anything at all.

Section 4 - Walking

- 0 Pain does not prevent me walking any distance.
- 1 Pain prevents me walking more than 1 mile.
- 2 Pain prevents me walking more than ¼ of a mile.
- 3 Pain prevents me walking more than 100 yards.
- 4 I can only walk using a stick or crutches.
- 5 I am in bed most of the time and have to crawl to the toilet.

Section 5 - Sitting

- 0 I can sit in any chair as long as I like.
- 1 I can sit in my favorite chair as long as I like.
- 2 Pain prevents me from sitting for more than 1 hour.
- 3 Pain prevents me from sitting for more than ½ hour.
- 4 Pain prevents me from sitting for more than 10 minutes.
- 5 Pain prevents me from sitting at all.

Section 6 - Standing

- 0 I can stand as long as I want without extra pain.
- 1 I can stand as long as I want but it gives me extra pain.
- 2 Pain prevents me from standing more than 1 hour.
- 3 Pain prevents me from standing for more than ½ an hour.
- 4 Pain prevents me from standing for more than 10 minutes.
- 5 Pain prevents me from standing at all.

Section 7 - Sleeping

- 0 My sleep is never disturbed by pain.
- 1 My sleep is occasionally disturbed by pain.
- 2 Because of pain, I have less than 6 hours sleep.
- 3 Because of pain, I have less than 4 hours sleep.
- 4 Because of pain, I have less than 2 hours sleep.
- 5 Pain prevents me from sleeping at all.

Section 8 - Sex life (if applicable)

- 0 My sex life is normal and causes no extra pain.
- 1 My sex life is normal but causes some extra pain.
- 2 My sex life is nearly normal but is very painful.
- 3 My sex life is severely restricted by pain.
- 4 My sex life is nearly absent because of pain.
- 5 Pain prevents any sex life at all.

Section 9 - Social Life

- 0 My social life is normal and cause me no extra pain.
- 1 My social life is normal but increases the degree of pain.
- 2 Pain has no significant effect on my social life apart from limiting my more energetic interests, i.e. sports.
- 3 Pain has restricted my social life and I do not go out as often.
- 4 Pain has restricted social life to my home.
- 5 I have no social life because of pain.

Section 10 - Travelling

- 0 I can travel anywhere without pain.
- 1 I can travel anywhere but it gives extra pain.
- 2 Pain is bad but I manage journeys of over two hours.
- 3 Pain restricts me to short necessary journeys under 30 minutes.
- 4 Pain prevents me from traveling except to receive treatment.

Section 11 - Previous Treatment

Over the past three months have you received treatment, tablets or medicines of any kind for your back or leg pain? Please check the appropriate box.

- 0 No
- 1 Yes (if yes, please state the type of treatment you have received)

Neck Disability Index

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage in everyday life. Please answer every section and mark in each section only the ONE box which applies to you. We realize you may consider that two of the statements in any one section relate to you, but please just mark the box which most closely describes your problem.

Section 1 – Pain Intensity

- I have no pain at the moment. (0)
- The pain is very mild at the moment. (1)
- The pain is moderate at the moment. (2)
- The pain is fairly severe at the moment. (3)
- The pain is very severe at the moment. (4)
- The pain is the worst imaginable at the moment. (5)

Section 2 – Personal Care (Washing, Dressing, etc.)

- I can look after myself normally without causing extra pain. (0)
- I can look after myself normally but it causes extra pain. (1)
- It is painful to look after myself and I am slow and careful. (2)
- I need some help but manage most of my personal care. (3)
- I need help every day in most aspects of self care. (4)
- I do not get dressed, I wash with difficulty and stay in bed. (5)

Section 3 – Lifting

- I can lift heavy weights without extra pain. (0)
- I can lift heavy weights but it gives extra pain. (1)
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table. (2)
- Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned. (3)
- I can lift very light weights. (4)
- I cannot lift or carry anything at all. (5)

Section 4 – Reading

- I can read as much as I want to with no pain in my neck. (0)
- I can read as much as I want to with slight pain in my neck. (1)
- I can read as much as I want with moderate pain in my neck. (2)
- I cannot read as much as I want because of moderate pain in my neck. (3)
- I can hardly read at all because of severe pain in my neck. (4)
- I cannot read at all. (5)

Section 5 – Headaches

- I have no headaches at all. (0)
- I have slight headaches that come infrequently. (1)
- I have moderate headaches which come infrequently. (2)
- I have moderate headaches which come frequently. (3)
- I have severe headaches which come frequently. (4)
- I have headaches almost all the time. (5)

Section 6 – Concentration

- I can concentrate fully when I want to with no difficulty. (0)
- I can concentrate fully when I want to with slight difficulty. (1)
- I have a fair degree of difficulty in concentrating when I want to. (2)
- I have a lot of difficulty in concentrating when I want to. (3)
- I have a great deal of difficulty in concentrating when I want to. (4)
- I cannot concentrate at all. (5)

Section 7 – Work

- I can do as much work as I want to. (0)
- I can do my usual work, but no more. (1)
- I can do most of my usual work, but no more. (2)
- I cannot do my usual work. (3)
- I can hardly do any work at all. (4)
- I cannot do any work at all. (5)

Section 8 – Driving

- I can drive my car without any neck pain. (0)
- I can drive my car as long as I want with slight pain in my neck. (1)
- I can drive my car as long as I want with moderate pain in my neck. (2)
- I cannot drive my car as long as I want because of moderate pain in my neck. (3)
- I can hardly drive at all because of severe pain in my neck. (4)
- I cannot drive my car at all. (5)

Section 9 – Sleeping

- I have no trouble sleeping. (0)
- My sleep is slightly disturbed (less than 1 hour sleepless). (1)
- My sleep is mildly disturbed (1-2 hours sleepless). (2)
- My sleep is moderately disturbed (2-3 hours sleepless). (3)
- My sleep is greatly disturbed (3-5 hours sleepless). (4)
- My sleep is completely disturbed (5-7 hours sleepless). (5)

Section 10 – Recreation

- I am able to engage in all my recreation activities with no neck pain at all. (0)
- I am able to engage in all my recreation activities, with some pain in my neck. (1)
- I am able to engage in most, but not all, of my usual recreation activities because of pain in my neck. (2)
- I am able to engage in a few of my usual recreation activities because of pain in my neck. (3)
- I can hardly do any recreation activities because of pain in my neck. (4)
- I cannot do any recreation activities at all. (5)

0-4	No disability
5-14	Mild disability
15-24	Moderate disability
25-34	Severe disability
> 35	Complete disability

PATIENT HEALTH INFORMATION CONSENT FORM

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. We 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 privacy of your Patient Health Information, we encourage you to read the HIPPA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions of the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply any care given after the request has been presented.
5. 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 this office to assure that your records are not readily available to those who do not need them.
6. Patient has the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and healthcare operations, our office has the right to refuse to give care.

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

Print Patient Name _____

Date: _____

Sign Patient Name _____

Spine Care of Alexandria, Inc.

INFORMED CONSENT
TO
CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy, and if necessary, diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible: See pt's signature below . . .) by the chiropractic physician and/or anyone working in this office authorized by the chiropractic physician.

I further understand that such chiropractic services may be performed by the physician of chiropractic named here Dr. Philip P. Connolly, D.C., D.A.C.A.N and/or other licensed Physician of chiropractic whom may treat me now or in the future at this office. I have had an opportunity to discuss with Dr. Connolly and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine and all health care, the practice of chiropractic carries some risks to treatment, including, but not limited to, fractures, disc injuries, and strokes (CVA), dislocations, and sprains. I do not expect that physician to be able to anticipate and explain all risks and complications. Further, I wish to rely on the physician to exercise judgment during the course of the procedure which the physician feels are in my best interests, at the time, based upon the facts then known.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its contents, and by signing below, I agree to the treatment recommended by my physician. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any condition(s) for which I seek treatment at this facility.

To be completed by the patient:

Print Patient's Name

Signature of Patient

To be completed by the patients
Representative, if necessary, (e.g.
If the patient is a minor or is
physically or mentally incapacitated)

Print name of Patient

Signature of Representative



SPINE CARE OF ALEXANDRIA, Inc.

Alexandria, Virginia 22310

Philip P. Connolly, D.C., D.A.C.A.N.
Diplomate of The American Chiropractic
Academy of Neurology

(703) 719-7302

DIRECT PAYMENT AUTHORIZATION

DATE: _____

PATIENT ACCOUNT # _____

AUTHORIZATION TO PAY PHYSICIAN DIRECTLY

I, _____, hereby instruct and direct the insurance company, _____ to pay by check made out to:

Spine Care of Alexandria

Alexandria, VA 22310

6285 Franconia Rd.

Or

If the current policy prohibits direct payment to a doctor, then I hereby also instruct and direct the insurance company to make the check payable to me and mail it as follows:

(Patient's Name)

c/o Spine Care of Alexandria

Alexandria, VA 22310

6285 Franconia Rd.

I instruct the insurance company to pay, in accordance with my above instructions, all the professional or medical expense benefits allowable, otherwise payable to me under the insurance policy as payment towards the total charges for the professional services rendered.

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY

I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment. A photocopy of this assignment shall be considered as effective and valid as the original.

Name of policy holder

Claim #

X _____
Signature of claimant, if other than policy holder

X _____
Witness

IRREVOCABLE ASSIGNMENT, AUTHORIZATION AND LIEN

To Whom It May Concern:

With this Irrevocable Assignment, Authorization and Lien (this "Assignment"), and in consideration of treatment without having to render concurrent payment, I, the undersigned patient, hereby irrevocably transfer set over and assign to SCAA (the "Health Care Provider") all insurance and/or litigation proceeds to which I am now or may hereafter become entitled, including those listed below, up to the total amount due and owing the Health Care Provider for services rendered to the undersigned by reason of accident or illness, including interest thereon, as well as any other charges that are due or may become due the Health Care Provider, including, without limitation, requested reports, collection costs and expenses and attorneys' fees, and I further hereby irrevocably authorize and direct any insurance company and/or attorney to whom an original or copy of this Assignment is provided to withhold from me and pay directly to such Health Care Provider such amount(s) from (1) any insurance benefits payable to me or on my behalf, including, but not limited to, medical payments benefits, No Fault benefits, health and accident benefits, foundation grants, governmental or agency benefits, worker's compensation benefits or any other insurance proceeds or benefits of any kind which are payable to or on behalf of the undersigned, and (2) any litigation proceeds (which may include insurance proceeds) from any settlement, judgment or verdict in my favor as may be necessary to fully pay any and all financial obligations owed to the Health Care Provider by the undersigned. This Assignment is to be a complete and current transfer of my right, title and interest, separate from any statutory or contractual lien or claim to which the Health Care Provider may also be entitled.

The undersigned patient further agrees that, in the event the insurance company and/or attorney obligated hereunder to make payments to the Health Care Provider fails or refuses to make payment for the full amount due as set forth above, this Assignment is to act as a full, immediate and complete assignment of all of the undersigned's rights, title, interest, remedies and benefits in and to the assigned property to the extent of the Health Care Provider's total claim amount; therefore, I hereby irrevocably assign and transfer to the Health Care Provider any and all causes of action that I might have or that might exist in my favor against such insurance company and/or attorney and authorize, and nominate and appoint as my attorney-in-fact any officer, of the Health Care Provider, to prosecute said cause(s) of action either in my name or in the Health Care Provider's name and further I authorize the Health Care Provider to compromise, settle or otherwise resolve said claim(s) or cause(s) of action as it sees fit.

I hereby further give a lien to said Health Care Provider against any and all insurance benefits and litigation proceeds outlined in the first paragraph above which may be payable to or on behalf of the undersigned as a result of the injuries or illness for which I have been treated by said Health Care Provider. The undersigned patient further agrees that the Health Care Provider's statute of limitations on its right to demand payment from the undersigned patient shall be tolled for all reasonable times that negotiations or litigation between third parties and the undersigned patient are ongoing.

Notwithstanding the foregoing, the undersigned patient agrees that until the Health Care Provider is paid in full, the undersigned shall remain personally and fully responsible for and promises to pay the total amount due the Health Care Provider (including principal, interest, collection costs and attorney's fees of 35%) until fully paid. The undersigned further understands and agrees that this Assignment does not constitute any agreement of or consideration for the Health Care Provider to await payments from any source, and in the event the Health Care Provider deems itself in its sole discretion insecure as to the prospect of payment, it may demand payments from me immediately upon rendering services at its option and proceed to collect same through legal means if necessary.

I authorize the Health Care Provider to release any information pertinent to my case to any insurance company, adjuster or attorney to facilitate collection under this Assignment. I hereby nominate and appoint any officer of the Health Care Provider as my attorney-in-fact to endorse/sign my name on any and all checks for payment of any indebtedness owed by me to the Health Care Provider and to negotiate same for payment of the services provided to me by said Health Care Provider.

Witness my signature and seal as of the indicated date:

Printed Name _____ Date _____ SSN# _____

Signature _____ Witness _____

Spine Care Associate of Alexandria, Inc.

Insurance Authorization Form Date _____

Last Name:	First Name & Initial:	Date of Birth:	M F
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Address: _____

City/State/Zip: _____

Home Phone:	Cell Phone:	Work Phone:
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Social Security Number:	Email:
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Employer: _____

Employer Address: _____

City/State/Zip: _____

Insurance Subscriber's Name (Last, First, M.I.): _____

Social Security Number:	Date of Birth:	Relationship to Patient:
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Address: _____

City/State/Zip: _____

Insurance Subscriber's Employer: _____

Emergency Contact Name: _____

Home Phone:	Cell Phone:	Work Phone:
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AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to Spine Care Associates of Alexandria, Inc., otherwise payable to me for services rendered, realizing I am responsible to pay non-covered services. **I also realize that I am responsible for any other cost incurred while collecting my outstanding balance(s).**

Signed _____ Date _____

Authorization to release information: I hereby authorize Spine Care Associates of Alexandria, Inc. to release any information acquired in the course of my treatment necessary to process insurance claims.

Signature (Legal Guardian/Parent, if minor) _____ Date _____

Waiver: _____

I, _____, agree to be seen by Spine Care Associates on this date. I acknowledge that I did not bring referral as required by my insurance company and/or I do not have my insurance card. I am electing to be seen today and agree to pay for services rendered since I do not have a valid referral or insurance card.

Signed _____ Date _____

Spine Care Associates of Alexandria
7025 C Manchester Blvd. 703-719-5628
6285 Franconia Rd. 703-719-7302
Alexandria, Va. 22310

Billing Agreement for Personal Injury Claims

I am choosing to only file my group medical insurance. I understand that I am fully responsible for any deductible, copay and or co-insurance at the time of service. I understand that I am waiving my right to file my automobile insurance.

I am choosing to file my personal automobile insurance. I understand that I am waiving my right to file my group medical insurance. I understand that I am fully responsible for any balance left unpaid due to maximums on my policy. A payment plan can be worked out at the end of said treatment .

Per agreement of Dr.Connolly, I have obtained an attorney and am agreeing to pay for my services out of my settlement with the other party. I understand that discounts will not be given in the event that settlement does not cover my total bill. A payment plan can be worked out at that time.

I have been explained my options and understand that this agreement will not be revoked or changed after treatment has begun.

Printed Name of Patient

Signature of Patient

Date