APPLICATION FOR CARE
COLUMBIA FAMILY CHIROPRACTIC
WELCOME TO OUR PRACTICE!

Today's Date: _____ ***Whom may we thank for referring you to this office?_____***

PATIENT DEMOGRAPHICS

Name: _____ Birth Date: _____-_____-_____ Age: _____ ☐ Male ☐ Female

Address: _____ City: _____ State: _____ Zip: _____

E-mail Address: _____ Home Phone: _____Mobile Phone:_____

Marital Status: ❑ Single ❑ Married Insurance: ❑ Yes ❑ No ❑ Military

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

Employer: _____ Occupation: _____

Spouse's Name: _____Spouse's Employer: _____

Number of children:_____ Ages: _____

Emergency Contact Name : _____Number:_____Relationship: _____

Primary Care Physician: _____

INSURANCE INFORMATION

Primary Insurance:_____Policy Number: _____
Policy Holder Name:_____Policy Holder DOB: _____

Secondary Insurance: _____ Policy Number: _____
Policy Holder Name:_____ Policy Holder DOB: _____

HISTORY of COMPLAINT

Please identify the condition(s) that brought you to this office:
On a scale of **1** to **10** with **10** being the worst pain and **zero** being no pain, rate your above complaints by c***ircling the number*:**

Primary complaint: _____**Primary** Pain Level : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Secondary complaint: _____**Second** Pain Level : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Third complaint: _____ **Third** Pain Level : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Fourth complaint:_____**Fourth** Pain Level : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

When did the problem(s) begin? _____ How did the injury happen?_____
When is the problem at its worst? ☐ AM ☐ PM ☐ mid-day ☐ late PM
How long does it last? ☐ It is constant **OR** ☐ I experience it on and off during the day **OR** ☐ It comes and goes throughout the week

What relieves your symptoms? _____

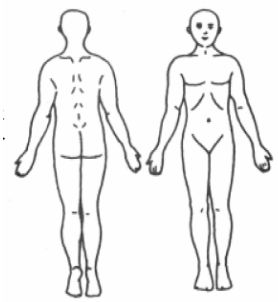
What makes them feel worse? _____

Has the condition(s) ever been treated by anyone in the past? □No □ Yes

If yes, by whom? _____How long were you under care: _____

What were the results? _____

Name of Previous Chiropractor: _____ □ **N/A**



***PLEASE MARK** the areas on the Diagram with the following **letters** to describe your symptoms:
R = Radiating **B = B**urning **D = D**ull **A =** Aching **N = N**umbness **S = S**harp/ **S**tabbing **T= T**ingling

LIST RESTRICTED ACTIVITY:	CURRENT ACTIVITY LEVEL	USUAL ACTIVITY LEVEL
_____:	_____	
_____:	_____	
_____:	_____	
_____:	_____	

Is your problem the result of ANY type of accident? ☐ Yes, ☐ No

Identify any other injury(s) to your spine, minor or major, that the doctor should know about:

_____

PAST HISTORY

Have you suffered with any of this or a similar problem in the past? ❑ No ❑ Yes **If yes** how many times? _____

When was the last episode? _____How did the injury happen?_____

Have you tried other forms of treatment: ☐ No ☐ Yes

If yes, please state **what** type of treatment: _____, and who provided it: _____

How long ago? _____ What were the results. ☐ Favorable ☐ Unfavorable please explain.

_____ _____

Please identify any and all types of jobs you have had in the past that have imposed any physical stress on you or your body:

_____

List Prescription & Nonprescription drugs you take: _____

_____

PLEASE identify ALL PAST and any **CURRENT** conditions you feel may be contributing to your present problem:

	HOW LONG AGO	TYPE OF CARE RECEIVED	BY WHOM
INJURIES			
SURGERIES			
CHILDHOOD DISEASES			
ADULT DISEASES			

SOCIAL HISTORY

1. Smoking: ❑cigars ❑ pipe ❑ cigarettes How often? ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never

2. Alcoholic Beverage: How often? ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never

3. Recreational Drug use: How often? ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never

4. Hobbies -Recreational Activities- Exercise Regime: How does your present problem affect the following:

FAMILY HISTORY:

1. Any other hereditary conditions the doctor should be aware of? ❑ No ❑Yes: _____

2. Does anyone in your family suffer with the same condition(s)? ❑ No ❑ Yes

If yes, whom: ❑ grandmother ❑ grandfather ❑ mother ❑ father ❑ sister's ❑ brother's ❑ son(s) ❑ daughter(s)

3. Have they ever been treated for their condition? ❑ No ❑ Yes ❑ I don't know

I hereby authorize payment to be made directly to Columbia Family Chiropractic, for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Columbia Family Chiropractic for any and all services I receive at this office.

_____ _____

Patient or Authorized Person's Signature **Date Completed**

_____ _____

Doctor's Signature **Date Form Reviewed**

PLEASE MARK "P" FOR PAST, "C" FOR CURRENT, AND "N" FOR NEVER FOR EACH OF THE FOLLOWING

___Headache	___Pregnant (Now)	___Dizziness	___Heart Problem	___High Blood Pressure
___Neck Pain	___Frequent Colds/Flu	___Fainting	___Prostate Problems	___Low Blood Pressure
___Jaw Pain/TMJ	___Convulsions/Epilepsy	___Vision Issues	___Impotence/Sexual Dysfunc	___Difficulty Breathing
___Shoulder Pain	___Tremors	___Ringing in Ears	___Diarrhea/Constipation	___Kidney Trouble
___Upper Back Pain	___Chest Pain	___Hearing Loss	___Digestive Problems	___Gall Bladder Trouble
___Mid Back Pain	___Pain with a Cough/ Sneeze	___Depression	___Colon Trouble	___Liver Trouble
___Low Back Pain	___Foot or Knee Problems	___Irritable	___Menopausal Problems	___Hepatitis (A, B, C)
___Hip Pain	___Sinus/Drainage Problem	___Mood Changes	___Menstrual Problems	___Rheumatoid Arthritis
___Back Curvature	___Swollen/Painful Joints	___ADD/ADHD	___Bed Wetting	___Osteoporosis
___Scoliosis	___Skin Problems	___Allergies	___Eating Disorder	___Asthma/Lung Problems
___Broken Bone	___Cerebral Vascular Problem	___Heart Attack	___Trouble Sleeping	___ Other (Describe)
___Dislocation	___Diabetes	___Ulcers	___Tumor (location _____	_____
___Numbness/Tingling (location _____)	___ Learning Disability	___Heartburn	___Cancer (location _____	_____

EFFECTS OF DAILY LIVING

Please identify how your current condition is affecting your ability to carry out activities that are routinely a part of your life:

	100% function	75% function	35% function	0% function
Bending	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Carrying	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Concentrating	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Doing Chores	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Doing Computer Work	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Dressing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Driving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Lifting	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Pushing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Rolling Over	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Running	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sitting	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sitting to Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sleeping	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Walking	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Working	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Playing Sports/Dancing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Recreational Activities	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform

QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name _____ Date _____

Please read carefully:

Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

Example:

	Headache		Neck		Low Back		
No pain							**worst possible pain**
0	**1**	**(2)**	**3**	**4**	**(5)**	**6**	**7**	**(8)**	**9**	**10**

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1 – What is your pain RIGHT NOW?

No pain _____ **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

2 – What is your TYPICAL or AVERAGE pain?

No pain _____ **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

3 – What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?

No pain _____ **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

4 – What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?

No pain _____ **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

OTHER COMMENTS:

_____

_____

_____

Examiner

Columbia Family Chiropractic's Office Policy

Welcome to Columbia Family Chiropractic

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your Personal Health Information. In addition we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as dictated by statements below, we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. Once you have read this notice, please sign the bottom. If you would like a copy for your records one will be provided for you.

PERMITTED DISCLOSURES:

- Treatment purposes: Discussion with other health care providers involved in your care.
- Inadvertent disclosures: Open treating areas mean open discussion, if you need to speak privately to the doctor please let our staff know so we can place you in a private consultation room.
- For payment purposes: To obtain payment from your insurance company or any other collateral source.
- For workers compensation purposes: To process a claim or aid in investigation.
- Emergency: In the event of a medical emergency we may notify a family member.
- For public health and safety: In order to prevent or lessen a serious or imminent threat to the health or safety of a person or general public.
- To government agencies or law enforcement: To identify or locate a suspect, fugitive, material witness or missing person.
- For military, national security, prisoner and government benefits purposes.
- Deceased persons: For discussion with coroners and medical examiners in the event of a patient's death.
- Telephone calls or emails and appointment reminders: We may call your home and leave messages regarding a missed appointment or update you of changes in practice hours or upcoming events.
- Change of ownership: In the event this practice is sold the new owners would have access to your PHI

YOUR RIGHTS:

- To receive an accounting of disclosures
- To receive a paper copy of the comprehensive detailed privacy notice
- To request mailings to an address different than residence
- To request restrictions on certain uses and disclosures and with whom we release information to although we are not required to comply. If however we agree, the restriction will be in place until written notice of your intent to remove the restriction.
- To inspect your records and receive one copy of your records at no charge, with notice in advance
- To request amendments to information, however like restrictions we are not required to agree to them.
- To obtain one copy of your records at no charge, when timely notice is provided (72 hours). X-rays are original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center to have copies made we will be happy to accommodate you, however you will be responsible for this cost.

I understand my rights as well as the practice's duty to protect my health information and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this "Notice of Privacy Practice" at any time in the future and will make the new provisions effective for all information that it maintains past and present. If you wish to make a formal complaint about how we handle your health information, please call the office at (803) 788-8831.

I am aware that a more comprehensive version of this notice is available to me and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

_____ _____

Patient Name (print) **DOB**

_____ _____ **Witness Initial** ☐

Patient Signature **Date**

Columbia Family Chiropractic's Office Policy

Welcome to Columbia Family Chiropractic

As a potential new patient,it is important that you understand our office policies regarding how patients of this practice are cared for, and the various methods we offer to facilitate payment for that care. Please read each policy carefully so there is no misunderstanding as to what you can expect as a patient of this practice, and what we expect in return. Once you have read 'Our Office Policies', if you have any questions or any of these policies are unclear to you, and you would like further explanation before submitting your ***Application for Treatment,*** please let our receptionist know and a member of our staff will be happy to discuss them with you further. We believe it is in everyone's best interests to provide potential new patients as much information as possible about how the doctors at this office practice chiropractic so that an informed decision can be made as to whether they wish to become a patient.

Over time, individuals who are accepted, as patients at this office, gain a greater understanding as to the purpose of chiropractic. Since the majority of patient care occurs in an open bay area, patients have a unique opportunity to observe firsthand the positive results that are achieved and the benefits derived from being under chiropractic care. This knowledge and awareness reaps a positive environment that promotes healing and encourages families to maintain good health. We want your experience with us to be an exceptional one, so help us to help you and together we can make affirmative changes in your life and the lives of those you care about.

□ **PATIENT PRIVACY –** Since the majority of patient care takes place in an open bay area it is important to understand that any conversations you have with the doctor can be overheard by other patients. In order to maintain patient privacy it is the policy of this practice to refrain from discussing any confidential matters with patients during treating hours while patients are being adjusted. If you have a confidential matter you wish to discuss please let us know and we will schedule time for you to speak to the doctor in a private consultation room. These consultations must be scheduled in advance.

□ **YOUR CARE** - When a patient seeks chiropractic health care and we agree to provide that care, it is essential for the patient and the doctor to be working toward the same objective. Chiropractic care at **Columbia Family Chiropractic** is rendered primarily to minimize and reduce subluxations, which are a major interference to the expression of the body's God-given, innate wisdom. The doctors use a myriad of techniques to accomplish this goal, including but not limited to Clear Institute, Pettibon, Full Spine, CBP, Toggle, Gonstead, and Activator. It is important that you understand both the objective and the method(s) so there is no confusion or disappointment. Tremendous progress has been made in the rehabilitating and correction of spinal problems. Where in the past, chronic spinal structural problems could not be reversed or corrected, today they can. Your doctor will outline a course of treatment that will take you beyond simple pain relief, through two distinct phases of care to make a structural correction to your spine that will enable your central nervous system to function optimally, thereby improving you overall health.

□ **FIRST THINGS FIRST**- Prior to receiving chiropractic care at this office, a health history and examination will be completed. Imaging studies as well as any other necessary diagnostics may also be ordered, to confirm the true nature of your condition and exact location of subluxations. The results of these procedures will aid in assessing your presenting problem, your overall health and, in particular, the condition of your spine. They will also assist the doctor in determining the type and amount of care you will need. All relevant findings will be reported to you along with care plan recommendations so that you can make the best possible decision regarding your health care needs. Our gold standard for care is to ensure the reduction of subluxation while teaching patients what they need to do in addition to being adjusted to maintain their health for a lifetime.

□ **PATIENT'S REPORT OF FINDINGS** – To enhance your understanding of the chiropractic approach that will be used to manage your health, immediately following your first adjustment, you will be scheduled for a 'Doctors Report of Findings'. The information you receive at this appointment will be both informative and clinically relevant to your case, therefore attendance is required for individuals who wished to become new patients of this practice. Because the results of your x-rays and all examinations as well as the doctors' recommendations for care, will be discussed at that time, we strongly urge new patients to invite their spouse or significant other to attend. We know from experience that when a patient's family understands the goals and objects of chiropractic care and how restoring and maintaining good health can affect their lives as well, they become infinitely supportive and helpful in making important decisions concerning treatment options.

I hereby acknowledge receiving a copy of the practices "Office Policies", the first page of which I have read and retained. This page is recognized by me as the signature page and will be retained by the practice as evidence of my receiving and understanding this "Notice". I further acknowledge that any concerns regarding these "Policies" as well as all my questions have been answered by a qualified member of the staff to my complete satisfaction.

_____ _____

Patient Name (print) **DOB**

_____ _____ **Witness Initial** ☐

Patient Signature **Date**

INFORMED CONSENT

REGARDING: Exam, X-Rays, Chiropractic Adjustments, Therapeutic Procedures, and Insurance

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective. It is important for each patient to understand both the objective and the method that will be used to attain it. This will prevent confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustment of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease, symptoms or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings we will recommend that you seek the services of the health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY OBJECTIVE is to eliminate interference to the expression of the body's innate wisdom. Our only method is the specific correction of vertebral subluxation.

Treatment objectives as well as the risks associated with chiropractic adjustments and all other procedures provided at Columbia Family Chiropractic have been explained to me to my satisfaction, and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to a full examination and treatment by any means, method, and or techniques, the doctor deems necessary to determine and treat my condition at any time throughout the entire clinical course of my care.

By my signature below I am acknowledging that the doctor and/or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

I hereby authorize payment to be made directly to Columbia Family Chiropractic, for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Columbia Family Chiropractic for any and all services I receive at this office.

_____ _____

Print Name **DOB**

_____ _____ **Witness Initial** ☐

Patient or Authorized Person's Signature **Date**

FEMALES ONLY: Please read carefully, and check the boxes, include the appropriate date, then sign above if you understand and have no further questions, otherwise see our receptionist for further explanation.

☐ The first day of my last menstrual cycle was on ____/____/____

Date

☐ I have been provided a full explanation of when I am mostly likely to become pregnant, and to the best of my knowledge, I am not pregnant.

CHIROPRACTIC

Columbia FAMILY CHIROPRACTIC

Automobile/PI Accident or Work Comp Questionnaire

Patient's Name _____ **DOB** _____ **HR#:** _____

Please answer all questions completely

Dear Patient: This information is considered confidential. We need this information because we care enough to want to know and your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. In order for us to understand your condition properly, please be as neat and accurate as possible while completing this form. Thank you.

Please explain in detail how your accident happened.

_____
_____
_____
_____

What was the time and date of the present injury?_____

Where did you feel pain immediately after the accident?

_____

List the extent of your injuries as you know them:

_____
_____
_____
_____
_____

Did you require post accident hospitalization? Yes/ No

Check symptoms you have noticed since the accident:

_____Headache	_____Dizziness	_____Depression	_____Fatigue
_____Light Bothers Eyes	_____Buzzing in Ears	_____Diarrhea	_____Neck Pain
_____Head Seems too Heavy	_____Memory Loss	_____Feet Cold	_____Neck Stiff
_____Pins and Needles in Arms	_____Ears Ring	_____Hands Cold	_____Fainting
_____Sleeping Problems	_____Back Pain	_____Face Flushed	_____Loss of Balance
_____Pins and Needles in Legs	_____Constipation	_____Tension	_____Nervousness
_____Numbness in Fingers	_____Loss of Smell	_____Fever	_____Irritability
_____Numbness in Toes	_____Loss of Taste	_____Chest Pain	_____Cold Sweats
_____Shortness of Breath	_____Stomach Upset		

Symptoms other than above:

_____

Where were you taken after the accident?

_____

Hospitalized? Yes/ No If yes, admitted? _____How long?

_____

Name of Hospital_____

Name of Doctors

_____

What treatment was given?

_____

Was any other doctor consulted after your accident? Yes/ No

If so, what was the doctor's name? _____ D.C., M.D., D.O., D.D.S.

What was the diagnosis?

_____

What treatment was given?_____

How often did you see the doctor?

_____

How long did you see the doctor?

_____

Have you ever had any complaints in the involved area before? Yes/ No

If so, what were the complaints?

_____

Before the injury were you capable of working on an equal basis with others your age? Yes/ No

Are your work activities restricted as a result of this accident? Yes/ No

Since this injury are your symptoms: Improving? Getting worse? Same?

Drive of other vehicle (if any)

Name_____Insurance Company_____ Policy No. _____

Driver of vehicle in which you were injured (if applicable)

Name_____ Insurance Company_____Policy No. _____

Name of your insurance adjustor

_____

Have you retained an attorney? Yes/ No

If so, his/her name and address_____

You were heading North/ East/ South/ West on _____(street or highway)

Other vehicle was heading North/ East/ South/ West on _____(street or highway)

Were police notified? Yes/ No

Were you knocked unconscious? Yes/ No If so, for how long?
_____

You were struck from Behind/ Front/ Left Side/ Right Side_____

You were Driver/ Passenger/ Front seat/ Back Seat/ Using seat belts_____

_____	_____	_____
Patient's Name	DOB	HR#:

_____	_____
Patient signature	DATE

_____	_____
Doctor signature	DATE

DOCTOR'S LIEN

TO: Attorney/ Insurance Carrier

_____
_____
_____
_____
_____

FROM: Doctor

Dr. Thomas Stetson
224 O'Neil Ct. Ste #21
Columbia, SC 29223
Phone: 803-788-8831
Fax: 803-788-8846

RE:

I do hereby authorize the above doctor to furnish you, my attorney/ insurance carrier, with a full report of his case history, examination, diagnosis, treatment, and prognosis of myself in regard to my accident/ illness which occurred/ began on _____.

I hereby give a lien to said doctor on any settlement, claim, judgment, or verdict as a result of said accident/ illness, and authorize and direct you, my attorney/ insurance carrier, to pay directly to said such sums as may be due and owing him for services rendered to me, and to withhold such sums from such I do hereby authorize the above doctor to furnish you, my attorney/ insurance carrier, with a full report of his settlement, claim, judgment, or verdict as may be necessary to protect said doctor adequately.

I fully understand that I am directly and fully responsible to said doctor for all chiropractic bills submitted by him for services rendered to me, and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. I further understand that such payment is not contingent on any settlement, claim, judgment, or verdict by which I may recover said fees.

Dated: _____Patient's Signature: _____

The undersigned, being attorney of record or authorized representative of insurance carrier for the above patient does hereby acknowledge receipt of the above lien, and agree to honor the same to protect adequately said above named doctor.

Dated: _____Authorized Signature: _____

NOTICE: Please date, sign, and copy this form.