

BACK



to Health Clinic

Stephen Walter, DC., & Associates
Gideon M. Tarnasky, DC. – Owen Fortney, DC.

ORTHOPEDIC AND NEUROLOGICAL SPINAL EXAM

Patient Name: _____ Patient DOB: _____ Date _____

OBJECTIVE FINDINGS

Age _____ Height _____ Weight _____ Temp _____ Eyes _____ Ears _____ Mouth _____
Blood Pressure R _____ / _____ L _____ / _____ Pulse _____ Throat _____ Heart _____ Abdomen _____

<p>STANDING EXAM</p> <p>Gait Evaluation _____ Rhomberg Test _____ Trendelenberg (hip) _____ Squat Test _____ Kemps (sciatic) _____ Heel Walk (L5) _____ Toe Walk (S1) _____ Belt Test _____ Adams _____</p>	<p>CRANIAL NERVES (I-XII) <input type="checkbox"/> WNL</p> <p>_____</p> <p>_____</p>	<p>PRONE EXAM</p> <p>Spinous Percussion _____ Ely's Test _____ Hibbs Test _____ Nachlas Test _____ Deerfield Sign _____ Mennell's Test _____ Yeoman's _____</p>
<p>THORACOLUMBAR ROM:</p> <p>Flexion (110) _____ Thor (50) _____ Lumb (60) _____ Extension (25) _____ Lat Flexion (25) Left _____ Right _____ Rotation (30) Left _____ Right _____</p>		<p>SUPINE EXAM</p> <p>SLR _____ R _____ L _____ Braggard's _____ Lasague _____ Goldthwait (lumbosacral) _____ Kernig's Sign _____ Patrick Fabere _____ Soto-Hall _____ Lindner's _____ Millgram's _____</p>
<p>SITTING EXAM</p> <p>Minor's Sign (lumbar) _____ Cervical Compression _____ Cervical Distraction _____ Shoulder Depression _____ Spurling's _____ Naffziger _____ Bechterew's _____</p>	<p>MOTOR (0-5) <input type="checkbox"/> WNL</p> <p>Shoulder Elevation (CN XI, C3-C6) L _____ R _____ Shoulder Abduction (C4-C6) L _____ R _____ Elbow Flexion (C5-C6) L _____ R _____ Elbow Extension (C6-C8) L _____ R _____ Wrist/Finger Flexion (C7-T1) L _____ R _____ Wrist/Finger Extension (C6-C8) L _____ R _____ Hip Flexion (L1-L3) L _____ R _____ Knee Extension (L2-L4) L _____ R _____ Knee Flexion (L4-S1) L _____ R _____ Plantar Flexion (L5-S2) L _____ R _____ Dorsiflexion (L4-L5) L _____ R _____</p>	<p>REFLEXES</p> <p>Achilles (S1-S2) Left 0 1 2 3 Right 0 1 2 3 Patellar (L2-L4) Left 0 1 2 3 Right 0 1 2 3 Biceps (C5-C6) Left 0 1 2 3 Right 0 1 2 3 Triceps (C6-C7) Left 0 1 2 3 Right 0 1 2 3 Radial (C6-T1).. Left 0 1 2 3 Right 0 1 2 3 Umbilical (8-9-D)..... 0 1 2 3</p>
<p>CERVICAL ROM:</p> <p>Flexion (60) _____ Extension (75) _____ Lat. Flexion (45) Left _____ Right _____ Rotation (80) Left _____ Right _____ O'Donoghue's Maneuver _____ Adson's _____ Eden's _____ Wright's _____</p>	<p>DYNAMOMETER</p> <p>R _____ / _____ / _____ L _____ / _____ / _____</p> <p>Patient is Right/Left handed.</p>	<p>MOTION PALPATION/COMMENTS</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>



Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

First Name: _____ Last Name: _____

Email address: _____@_____

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: __/__/____ Gender (Circle one): Male / Female Preferred Language: _____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

CMS requires providers to report both race and ethnicity

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian)
Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

I choose to decline receipt of my clinical summary after every visit (These summaries are often blank as a result of the nature and frequency of chiropractic care.)

Patient Signature: _____ Date: _____

For office use only

Height: _____ Weight: _____ Blood Pressure: _____ / _____

**ACKNOWLEDGEMENT OF RECEIPT OF
Notice of Privacy Practices
of BACK to Health Clinic & Natural Recovery Massage, LLC
Stephen Walter, DC- Gideon Tarnasky, DC- Owen Fortney, DC
Diesha Raish, LMT**

Patient Name: _____ Patient# or SSN: _____

Address: _____ City: _____ State: _____ ZIP: _____

Email: _____ Phone: (____) _____ - _____ Cell/Home/Wk

I have been given or offered a copy of the Notice of Privacy Practices of BACK to Health Clinic and Natural Recovery Massage, which describes how my health information is used and shared. I understand that either BACK to Health Clinic or Natural Recovery Massage has the right to change this Notice at any time. I may obtain a current copy by contacting the Facility Privacy Official or by visiting the Facility website at salembackdoctor.com.

My signature below acknowledges that I have been provided or offered a copy of the Notice of Privacy Practices:

Signature of Patient or Personal Representative

Date

Printed Name

Personal Representative's Title (e.g. Guardian, Executor of Estate, Health Care Power of Attorney)

For Clinic Use Only: Complete this section if you are unable to obtain a signature.

1. If the Patient or personal representative is unable or unwilling to sign this Acknowledgement, or the Acknowledgement is not signed for any other reason, state the reason:

2. Describe the steps taken to obtain the patient's or personal representative's signature on the Acknowledgement:

Completed by:

Signature of Clinic Representative

Date

Printed Name

Scan or file original in Patient's Records.

WELCOME

PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name _____
First Name _____ Middle Initial _____

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex M F Age _____

Birthdate _____

Married Widowed Single Minor
 Separated Divorced Partnered for _____ years

Occupation _____

Patient Employer/School _____

Employer/School Address _____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? Yes No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to _____
Name of Insurance Company(ies)

Dr. Back to Health Clinic all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative _____

Please print name of Patient, Parent, Guardian or Personal Representative _____

Date _____ Relationship to Patient _____

PHONE NUMBERS

Home Phone (_____) _____

Cell Phone (_____) _____

Best time and place to reach you _____
IN CASE OF EMERGENCY, CONTACT

Name _____

Relationship _____

Home Phone (_____) _____

Work Phone (_____) _____

ACCIDENT INFORMATION

Is condition due to an accident? Yes No

Date _____

Type of accident Auto Work Home Other

To whom have you made a report of your accident?
 Auto Insurance Employer Worker Comp. Other

Attorney Name (if applicable) _____

JEFFERY W. BAKER D.C., P.C.
dba BACK to Health Clinic
4630 River Rd. N., Suite A
Keizer, OR 97303

PATIENT CONDITION

ADDRESS SERVICE REQUESTED

Reason for Visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? Yes No Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

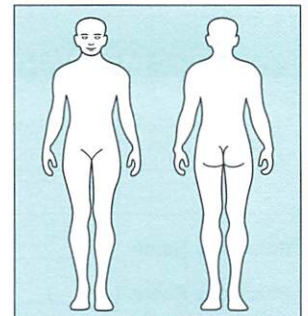
Type of pain: Sharp Dull Throbbing Numbness Aching Shooting
 Burning Tingling Cramps Stiffness Swelling Other

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your Work Sleep Daily Routine Recreation

Activities or movements that are painful to perform Sitting Standing Walking Bending Lying Down



HEALTH HISTORY

What treatment have you already received for your condition? Medications Surgery Physical Therapy
 Chiropractic Services None Other _____

Name and address of other doctor(s) who have treated you for your condition _____

Date of Last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____
 Spinal Exam _____ Chest X-Ray _____ Urine Test _____
 Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

- | | | | | | | | | | | | |
|---------------------|------------------------------|-----------------------------|---------------------|------------------------------|-----------------------------|----------------------|------------------------------|-----------------------------|------------------------------|------------------------------|-----------------------------|
| AIDS/HIV | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Diabetes | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Liver Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Rheumatic Fever | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Alcoholism | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Emphysema | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Measles | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Scarlet Fever | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Allergy Shots | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Epilepsy | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Migraine Headaches | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Sexually Transmitted Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Anemia | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Fractures | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Miscarriage | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Stroke | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Anorexia | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Glaucoma | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Mononucleosis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Suicide Attempt | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Appendicitis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Goiter | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Multiple Sclerosis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Thyroid Problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Arthritis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Gonorrhea | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Mumps | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Tonsillitis | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Asthma | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Gout | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Osteoporosis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Tuberculosis | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Bleeding Disorders | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Heart Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Pacemaker | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Tumors, Growths | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Breast Lump | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Hepatitis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Parkinson's Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Typhoid Fever | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Bronchitis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Hernia | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Pinched Nerve | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Ulcers | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Bulimia | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Herniated Disk | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Pneumonia | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Vaginal Infections | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cancer | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Herpes | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Polio | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Whooping Cough | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cataracts | <input type="checkbox"/> Yes | <input type="checkbox"/> No | High Blood Pressure | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Prostate Problem | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Other _____ | | |
| Chemical Dependency | <input type="checkbox"/> Yes | <input type="checkbox"/> No | High Cholesterol | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Prosthesis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | | |
| Chicken Pox | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Kidney Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Psychiatric Care | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | | |
| | | | | | | Rheumatoid Arthritis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | | |

<p>EXERCISE</p> <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Daily <input type="checkbox"/> Heavy	<p>WORK ACTIVITY</p> <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Light Labor <input type="checkbox"/> Heavy Labor	<p>HABITS</p> <input type="checkbox"/> Smoking Packs/Day _____ <input type="checkbox"/> Alcohol Drinks/Week _____ <input type="checkbox"/> Coffee/Caffeine Drinks Cups/Day _____ <input type="checkbox"/> High Stress Level Reason _____
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Are you pregnant? Yes No Due Date _____

Injuries/Surgeries you have had	Description	Date
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____

MEDICATIONS	ALLERGIES	VITAMINS/HERBS/MINERALS
_____	_____	_____
_____	_____	_____
_____	_____	_____
Pharmacy Name _____	_____	_____
Pharmacy Phone (____) _____	_____	_____

BACK



to Health Clinic

Stephen Walter, DC.- Gideon M. Tarnasky, DC- Owen Fortney, DC.

PERMISSION TO RELEASE CONFIDENTIAL INFORMATION TO A FAMILY MEMBER, FRIEND OR LEGAL REPRESENTATIVE.

IMPORTANT NOTICE: The law prohibits the release of confidential medical information to an entity without the written voluntary consent of the undersigned patient.

Name of Patient: _____ Date of Birth: _____

❖ BACK to Health Clinic may leave messages on my phone YES NO

❖ I authorize BACK to Health Clinic to confirm appointments and/or discuss information regarding my medical condition with: (spouse, relatives, friends)

_____	_____	_____
Name	Phone	Relationship
_____	_____	_____
Name	Phone	Relationship

If you do not want any information given to anyone other than yourself please initial here _____

I understand this Authorization. I also understand that the information used or disclosed may be subject to re-disclosure by the recipient and no longer protected under federal law. I understand this document is not a release of medical records.

Signature of Patient Date

Signature of Legal Representative Date

Printed Name of Legal Representative Date

**BACK to Health Clinic
Financial and Billing Policy**



General Billing Information- ALL CASE TYPES

All new patients must provide picture ID at their first visit and as requested thereafter, as required by federal law. Inability to show valid picture ID will force us to reschedule your appointment for a later time when valid picture ID can be provided. All new patients must complete and sign new patient paperwork.

All out of pocket costs are due at the time of service. We accept Visa, MasterCard, Discover and Care Credit for your convenience. On occasion, coinsurance and deductibles may only be determined after your insurance has been billed. This may leave a balance on your account. If you have a balance, invoices will be sent at the beginning of each month. Invoiced accounts that remain unpaid by the next billing cycle will be subject to a \$10 late fee. The late fee will reoccur each month that the balance remains unpaid, up to a total of not more than 3 months. Accounts with returned checks will be charged a \$30 returned check fee. An account may be sent to a collection's agency at any point in time once it has become delinquent, at the discretion of the BACK to Health Clinic billing staff. Please direct all billing inquiries to 503-689-1929 ***phone payments are gladly accepted***

Self Pay Patients

All self-pay patients are required to pay at time of service. We accept Visa, MasterCard, Discover and Care Credit. Our "My Wellness Card" program is also a great option for individuals or families without chiropractic coverage. It's affordable, flexible and can be transferred or gifted. Please ask our receptionist for more details or pick up a brochure at the front desk. All durable medical equipment (e.g., pillows, braces, and supplements) must be paid for at time of service.

Medical Records

Medical records will be provided to other healthcare providers for coordination of care at no cost. Should you desire a copy of your records for yourself, we will charge reasonable, cost-based fees per, ORS 192.521. Personal copies are \$30 for up to the first 10 pages and .50 cents for each additional page. Copy fees must be paid in full, and an authorization signed prior to copies being prepared. Please be prepared to show picture ID when picking up copies of your medical records. Medical records will only be release to the person or entity listed on the release of medical records form. Medical record requests may take up to 30 days to complete.

Private/ Group Health Insurance

(Please remember that insurance estimates are based on information provided by your insurance company. Eligibility and benefits quoted by insurance are an estimate only and not a guarantee of payment. Please have your updated insurance card ready to show our receptionist at the time of your visit)

Your insurance is a contract between you and your insurance carrier and may involve your employer. We have no control over your benefits. You are ultimately responsible for checking with your plan directly to see what chiropractic benefits you have and to obtain any needed referral or authorization from your primary care provider or plan. Some insurance contracts may not cover all provided services. Services are provided based on medical necessity, NOT the assumption that the charges will be paid by the insurance. **You are ultimately responsible for treatment costs that are not covered by insurance.** It is your responsibility to provide us with any updates or changes to your insurance. Failure to do so could result in denial of your claims and payment would automatically become your responsibility. All out of pocket costs are due at time of service. We accept Visa, MasterCard, Discover and Care Credit.

Medicare

BACK to Health Clinic does accept and bill Medicare. If you have a secondary insurance or a supplement, please provide it at the time of service. We do not participate with all Medicare secondary insurers. You are responsible for all amounts not paid, due to non-participation with your secondary insurer. You are also responsible for all deductibles and coinsurance left by Medicare. You may be asked to sign an Advanced Beneficiary Notice for any maintenance care or service that we believe may not be covered by Medicare.

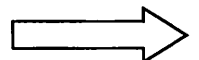
Oregon Health Plan/ Medicaid

BACK to Health Clinic is currently unable to accept Oregon Health Plan/ Medicaid, for chiropractic treatment. If Oregon Health Plan (Medicaid) is your secondary insurer, costs not covered by your primary plan will be solely your responsibility.

Motor Vehicle Collision Patients

BACK to Health Clinic gladly treats patients injured in Motor Vehicle Collisions (MVC). We will bill the insurance of the vehicle you were occupying at the time of the injury directly. If you have private insurance, you are required to provide that information at the beginning of your treatment. This information will be used if you exhaust the personal injury benefit provided by your auto policy. In this event, you will be responsible for any co-pays, deductibles or coinsurance associated with your private health insurance policy.

BACK to Health Clinic
4630 River Rd. N., Suite A
Keizer, OR 97303
P# 503-304-2225 F# 503-304-2226
Stephen Walter, DC.- Gideon Tamasky, DC.- Owen Fortney, DC



Workers Compensation Patients

BACK to Health Clinic gladly treats patients with work related injuries. We may treat for a total of 60 days or 18 visits on the initial claim. Treatment beyond this timeframe may require a referral from an attending Physician. Please inform the office if you receive notice that you are being enrolled in a Managed Care Organization (MCO) as this will affect the circumstances under which we may treat you. We will bill your employer’s workers compensation insurer directly. If you have private insurance, you are required to provide that information at the beginning of your treatment. This information will be used if your claim is denied. In this event, you would be responsible for any deductibles, co-pays or coinsurance associated with your private health plan. These costs will be collected only after a denied, un- appealed claim.

Irrevocable Doctor’s Lien and Assignment or Right to Recovery

In consideration and exchange for not having to immediately pay a debt owed and in consideration for receiving future care through the doctors of BACK to Health Clinic, each new patient treating for a Motor Vehicle Collision (MVC), Workers Compensation, Slip Fall, or any type of third party liability claim, whether you have an attorney or not, must sign a Doctor’s Lien to guarantee us payment for services rendered, against any settlement you might receive on your case. Your signature also provides us permission to forward your unpaid bills to the attorney for coverage instead of having to bill you directly. Doctors Lien’s allow your attorney to pay any outstanding bills related to your claim to BACK to Health Clinic directly.

Medical Massage

BACK to Health Clinic provides medical massage, performed by Certified Medical Massage Therapists and Certified Chiropractic Assistants. Medical Massage is *Injury Care by Dr’s Referral for Diagnosed Conditions*. It focuses on treatment of pain, spasm, swelling and/or limited motion, *often* due to traumatic injury. A medical massage is currently \$215 Dollars for 60 minutes (\$53.63 per unit). Necessary units are determined by referring physician and will not be performed until a Dr’s referral is obtained. No discounts, certificates or special promotions will be honored for medical massage. ***Our therapists will not perform medical massage under pretense or cost of a wellness massage.*** Gift cards or referral certificates may *not* be used for *medical massage*.

Wellness Massage

BACK to Health Clinic no longer offers wellness massage to the public.

Department of Transportation (DOT) Physicals

Our doctors are licensed Certified Medical Examiners by the Federal Motor Carrier Safety Administration (FMCSA) National Registry. A copy of your exam results will be furnished to you and a medical examiners certificate will be provided to you for proof of passed exam. DOT Physicals will not be billed to insurance and must be paid prior to your exam. If you fail the exam, you are still required to pay. A onetime courtesy retake will be provided at no cost if you need to see another provider to resolve a medical issue that caused you to fail the exam. Retake exams must be done within 90 days of failed exam. A medical examiners certificate is good for up to 24 months.

Sports Physicals

Our doctors perform sports physicals year-round. The doctor will fill out the necessary documentation to be provided to the entity requiring the physical. Sports Physicals are currently \$45. This must be paid prior to exam by cash, credit, or debit. We do not accept checks for these exams. Sports Physicals will not be billed to private/ group health insurance. BACK to Health Clinic is unable to perform physicals for “Boy Scouts of America”. They have specific criteria and can provide you with a list of approved examiners in your area.

PATIENT AGREEMENT AND ASSIGNMENT OF BENEFITS: I hereby assign Back to Health Clinic, the insurance benefits that are otherwise payable to me for charges relating to my care. I also direct my insurance company to make payment directly to this clinic on my behalf. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not I have insurance, and agree to pay all fees, including attorney fees, associated with the collection of this debt. I hereby authorize assignee to release all information necessary to secure payment. Please let us know if you have any questions about our Financial and Billing Policy. Your signature below will confirm that you have *read* and *understand* our Financial and Billing Policy.

Signature of Guarantor

Date