FOLLETO DE INFORMACION

(Patient Information Sheet)

FECHA DE HOY: _____ *(Today's Date)* **SEXO: M ( ) F ( )** **FECHA DE LESSION:** _____ *(Date of Injury)*

APELLIDO: _____ *(Last Name)* **NOMBRE:** _____ *(First Name)*

DOMICILIO: _____ *(Address)* **Apt. #** _____

Ciudad *(City)* _____ **Estado** *(State)* _____ **Codigo Postal** *(Zip)* _____

 # TEL. CASA: ( ) _____ *(Home #)* **# TEL. TRABAJO:** ( ) _____ *(Work #)* **CELULAR:** ( ) _____ *(Cell#)*

 # SEGURO SOCIAL *(S.S. #)*: _____ **FECHA DE NACIEMENTO** *(D.O.B.)*: _____

 # LICENSIA: _____ *(Driver's license)* **ESTADO CIVIL:** *(Marital Status)* **( ) Casado** *(Married)* **( ) Soltero** *(Single)* **( ) Viudo** *(Widow)* **( ) Divorciado** *(Divorced)*

NOMBRE DE CONYUGE O TUTOR: _____ *(Spouse/Guardian Name)* **DOMICILIO:** _____ *(Address)*

ENCASO DE EMERGENCIA POR FAVOR NOTIFIQUE A : *(In case of an emergency please notify person not living in your household)*

APELLIDO: _____ *(Last Name)* **NOMBRE:** _____ *(First Name)* **TEL:** ( ) _____

_____

SEGURO DE SALUD PRIVADO: _____
(Private Health Insurance Co. / must include name AND address)

DOMICILIO *(Address)*: _____

NUMERO DE POLISA *(policy #)*: _____ **GRUPO** *(Group)*: _____

RELACION CON EL SUSCRIPTOR *(Subscriber/Relationship)*: _____

COBERTURA DE SEGURO DE AUTO: _____ **TEL:** ( ) _____
(Auto Insurance Coverage)

NUMERO DE POLISA *(policy #)*: _____ **RELACION CON EL SUSCRIPTOR** *(Subscriber/Relationship)*: _____

Favor de leer y firmar:

Cession y Divulgacion

Certifico que yo y/a mi(s) persona(s) a cargo contamos con cobertura de seguro de _____
Nombre de la(s) Compañia(s) de seguro

y cedemos directamente al Dr._____ todos los beneficios del seguro, si los hubiere, de otro modo pagaderos a mi por servicios prestados. Comprendo que soy responsable desde el punto de vista financiero por todos los cargos, sean o no pagados por el seguro. Autorizo el uso de mi firma en todos los documentos del seguro.

_____ _____

Firma del Paciente, padre/madre, tutor o representante personal Fecha

_____

Indicar nombre del Paciente, padre/madre, tutor o representante personal

_____

Relacion con el Paciente

OCUPACION *(Occupation)*:_____ DESCRIPCION DE TRABAJO *(Brief Job Description)*:_____

( ) Mano Derecha *(Right-handed)* ( ) Mano Izquierda *(Left-handed)*

Historia Del Daño *(History of Injury)*

TIPO DE ACCIDENTE *(Nature of Accident)*:

( ) Vehiculo *(Auto)* ( ) Caida *(Slip and fall)* ( ) Peaton *(Pedestrian)* ( ) Trabajo *(Work Related)* ( ) Asalto *(Assault)* ( ) Otro (Explicar) *(Other, Explain)*_____

Si no fue accidente de Auto, describa lo que paso. *(If non-motor vehicle accident, describe the injury)*: _____

_____

_____

Informacion sobre el Accidente de AUTO solamente: *(Motor Vehicle Information Only)*:

circule o marque una

Paciente era el: *Patient was the:* ( ) Chofer *(driver)* ( ) El pasajero y estaba... *(passenger in the...)* ( )adelante *(front seat)* ( )detras *(rear)* (medio, izquierda, derecha) *(middle, left, right seat)* ( )cajuela de la camioneta *(bed of pickup)*

Paciente: *Patient was* ( ) tenia el cinturon puesto *(Wearing seatbelt)* ( ) no tenia el cinturon puesto *(Not wearing seatbelt)*

Auto del Paciente: *Patient's Vechicle* ( ) Auto *(Car)* ( ) Van *(Van)* ( ) Camioneta *(Pick-Up Truck)* ( )Motocicleta *(Motorcycle)* ( ) Bicicleta *(Bicycle)* ( ) Otro (Explicar) *(Other, Explain)*_____

Contra: *Versus:* ( ) Auto *(Car)* ( ) Van *(Van)* ( ) Camioneta *(Pick-Up Truck)* ( ) Motocicleta *(Motorcycle)* ( ) Bicicleta *(Bicycle)* ( ) Otro (Explicar) *(Other, Explain)*_____

Vehiculo Del Paciente estaba: *Patient's vehicle was* ( ) Parado *(At a stop)* ( ) Empesando a mover *(Starting to move)* ( ) Bajando la velocidad *(Slowing down)* ( ) Moviendo *(Moving)*

Donde fue el golpe? *Where was it struck?*

( ) **POR DETRAS** *(From behind)* ( ) Guardabarros derecha *(Right fender)* ( ) Guardabarros izquierda *(Left fender)*

( ) **ADELANTE** *(Head on)* ( ) Guardabarros derecha *(Right fender)* ( ) Guardabarros izquierda *(Left fender)*

( ) **EN LADO** *(Sideswiped)* ( ) Derecha *(Right side)* ( ) Izquierda *(Left side)*

El Paciente estaba: *The patient was:* ( )Desprevenido *(unprepared)* ( ) Tenia la cabesa volteada: a la derecha *(right)* izquierda *(left)* detras *(rear)* ( ) Apoyado contra el Porta Brasos *(leaning on armrest)*

Al momento del impacto, el paciente: *(On impact, the patient)* ( ) Refuerzo el cuerpo para el impacto *(Braced for impact)* ( ) Pizo los frenos *(Stepped hard on brakes)* ( ) Detubo fuerte el volante *(Forcibly held on to steering wheel)*

Al momento, su cuerpo fue: *(Thereafter, the patient's body was)* ( ) Sacudido de enfrente a atras *(Jolted back and forth)* ( ) Sacudido de lado a lado *(Jolted from side to side)* ( ) Otra *(Other, Explain)*_____

Despues Del Impacto *(Following the Impact)*:

El Paciente indica: *Patient Indicates* ( ) No perdio el conocimiento *(Denied loss of consciousness)* ( ) Perdio el conocimiento *(Lost consciousness)* ( ) por segundos *(Momentarily)* ( ) por minutos *(Several minutes)*

Despues del accidente se sintio: *Thereafter felt*

( ) Nervioso/*Nervous* ( ) Sobresaltado/*Surprised* ( ) Aturdido/*Stunned or Dazed*

( ) Panico/Panicky ( ) Confundido/*Confused* ( ) Desorientado /*Disoriented*

( ) Asustado/Scared ( ) Ganas de vomitar /*Nauseated* ( ) Mareado/*Lightheaded or Dizzy*

( ) Otra/*Other*_____

El paciente experimento: *(The Patient experienced)* ( ) Vomito *(Vomiting)* ( ) Convulsiones *(Convulsions)* ( ) No recuerdo los eventos de el accidente *(Poor recollection of events)*

Paciente Sufrio: *Patient sustained:* ( ) Golpe(s) a la cabesa *(Head injuries)* ( ) Sangrando / Heridas a la cabesa *(Scalp bleeding / lacerations)* ( ) Cortadas / Moretes en *(Cuts / Bruises on...)*_____

Paciente sintio dolor: ( ) **Inmediatamente despues del accidente** ( ) **Horas despues** ( ) **Al siguente dia** ( ) **Dias despues**
Patient noted pain: *(Immediately following the accident)* *(Hours later)* *(The next morning)* *(Over the next few days)*

Sintio Dolor en: *(Pain located):* ( ) **Cabeza**/*Head* ( ) **Pecho**/*Chest* ( ) **Abdomen**/*Abdomen*

( ) **Cuello**/*Neck* ( ) **Espalda Superior**/*Upper back* ( ) **Espalda Media**/*Mid Back* ( ) **Cintura**/*Lower Back*

( ) **Hombro**/*Shoulder* ( ) **derecha**/*right* ( ) **izquierda**/*left* ( ) **Pierna**/*Leg...* ( ) **derecha**/*right* ( ) **izquerda**/*left*

( ) **Brazo**/*Arm* ( ) **derecha**/*right* ( ) **izquierda**/*left* ( ) **Musio**/*Thigh...* ( ) **derecha**/*right* ( ) **izquerda**/*left*

( ) **Codo**/*Elbow...* ( ) **derecha**/*right* ( ) **izquierda**/*left* ( ) **Rodilla**/*Knee...* ( ) **derecha**/*right* ( ) **izquierda**/*left*

( ) **Mano**/*Hand...* ( ) **derecha**/*right* ( ) **izquierda**/*left* ( ) **Pie**/*Foot...* ( ) **derecha**/*right* ( ) **izquierda**/*left*

( ) **Muñeca**/*Wrist...* ( ) **derecha**/*right* ( ) **izquierda**/*left* ( ) **Tobillo**/*Ankle...* ( ) **derecha**/*right* ( ) **izquierda**/*left*

( ) **Dedos**/*Fingers...* ( ) **derecha**/*right* ( ) **izquierda**/*left* ( ) **Dedos del Pie**/*Toes...* ( ) **derecha**/*right* ( ) **izquierda**/*left*

Despues Del Accidente *(After the Accident):*

Paciente fue a: ( ) **Casa** ( ) **Trabajo/Escuela** ( ) **Al Hospital, via...** ( ) **Paramedicos** ( ) **Usted mismo**
Patient went *(Home)* *(Back to work/school)* *(To hospital via...* *(Paramedics)* *(Self)*

Nombre Del Hospital/Clinica Medica *(Hospital Name/Medical Center)* _____

Fue internado, Fecha *(Date admitted)* _____ **Fecha de Alta** *(Released)* _____

Tratamiento que recibio en Hospital/Clinica *(Treatment rendered at hospital/center)*_____

_____

Lista de otros doctores que ha visto por causa de ESTE ACCIDENTE *(List any other physicians seen as a result of THIS ACCIDENT):*

_____

_____

Que medicamento, fisioterapia o tratamiento quiropractico ha recibido por causa de ESTE ACCIDENTE? *(To date, what medication(s). physical therapy or chiropractic treatment has the patient undergone or received as a result of THIS ACCIDENT)?* _____

_____

_____

Sigue recibiendo tratamiento? ( ) **No** ( ) **Si/Yes** **Fecha de ultimo tratamiento:** _____
(Is the patient still being treated)? *(Date of Last Treatment)*

Dolores Actuales *(Current Complaints)*

DOLORES DE CABEZA *(Headaches):*

Frequencia/*Frequency***:** ( ) **Constante/***Constant* **O/***OR* ( ) **Viene o se va/***Intermittent(comes and goes)*

Intensidad/*Intensity***:** ( ) **Minimo** *(Minimal)* ( ) **Ligeramente** *(Slight)* ( ) **Moderado** *(Moderate)* ( ) **Severo** *(Severe)*

Como/*Nature***:** ( ) **Agudo** *(Sharp)* ( ) **Pulsante** *(Pulsating/throbbing)* ( ) **Con Presion** *(Pressure-type)* ( ) **Punzante** *(Sharp stabbing)* ( ) **Partiendo** *(Splitting)*

Donde esta localisado el dolor: *(location of pain)* ( ) **Toda la Cabeza** *(All over the head)* ( ) **Area de Frente** *(Frontal are)* ( ) **Detras** *(Back)* ( ) **Lado Derecho** *(Right side)* ( ) **Lado Izquierdo** *(Left side)*

DOLORES ACTUALES (CONTINUACION)/*CURRENT COMPLAINTS (CONTINUED)*

( ) Dolor de Pecho/*Chest pain*	( ) Hombro/*Shoulder*	( ) D/*R* ( ) I/*L*	( ) Cadera/*Hip*	( ) D/*R* ( ) I/*L*
( ) Abdominal/*Abdominal pain*	( ) Brazo/*Upper arm*	( ) D/*R* ( ) I/*L*	( ) Pierna/*Leg*	( ) D/*R* ( ) I/*L*
( ) Enfrente del Cuello/*Neck front*	( ) Codo/*Elbow*	( ) D/*R* ( ) I/*L*	( ) Muslo/*Thigh*	( ) D/*R* ( ) I/*L*
( ) Cuello/Nuca /*Neck back*	( ) Ante brazo/*Forearm*	( ) D/*R* ( ) I/*L*	( ) Rodilla/*Knee*	( ) D/*R* ( ) I/*L*
( ) Costado/*Upper /mid back*	( ) Muñeca/*Wrist*	( ) D/*R* ( ) I/*L*	( ) Tobillo/*Ankle*	( ) D/*R* ( ) I/*L*
( ) Cintura/*Lower back*	( ) Mano/*Hand*	( ) D/*R* ( ) I/*L*	( ) Pie/*Feet*	( ) D/*R* ( ) I/*L*

Tiene moretes, inflamacion,, raspones, o cortadas? Explique en detalle *(Any bruises, swelling, abrasions, lacerations? If so, explain in detail)*:

_____

_____

_____

Marque las quejas relacionadas *(Mark any of the following associated complaints)*:

( ) **Vision Borroso**/*Blurred Vision* ( ) **Nausea/vomito**/*Nausea/Vomiting* ( ) **Perdida de Balance**/*Loss of Balance* ( ) **Mareos**/*Dizziness*
( ) **Perdida de Memoria**/*Memory Loss* ( ) **Problemas de Dijestion**/*Digestion Problems* ( ) **Perdida de Apetito**/*Loss of Appetite*
( ) **Problemas Recordando**/*Absent Mindedness* ( ) **Nerviosismo**/*Nervousness* ( ) **Confusion**/*Confusion* ( ) **Ansiedad**/*Anxiety*
( ) **Sumbido de Oidos** /*Ringing Noise in the Ears* ( ) **Insomnio**/*Insomnia* ( ) **Tension**/*Tension* ( ) **Inquietud**/*Restlessness*
( ) **Ganas de Llorar**/*Crying Spell* ( ) **Depresion**/*Depression* ( ) **Problemas de la Vejiga**/*Bladder Problems*

( ) **Cojear a causa de dolor en** /*Limping due to pain in* ... ( ) **derecha**/*right* ( ) **izquierda**/*left extremity*

Describe algun dolor que extende, entumido o piquetes/*Describe any radiating pain; numbness or tingling sensations*:

_____

Describe partes de su cuerpo que truenan con movimiento/*Describe any locking, snapping, crackling, popping)*:_____

_____

Actividades que Aumentan el dolor *(Activities that increase pain)*:

( ) **Agachando** /*Bending* ( ) **Cargando**/ *Carrying* ( ) **Extenderse**/*Extending* ( ) **Caminando**/ *Walking*
( ) **Empujando**/*Pushing* ( ) **Sentando** /*Sitting* ( ) **Sentadillas** /*Squatting* ( ) **Torsiendo**/*Twisting*
( ) **Volteando**/*Turning* ( ) **Parado**/*Standing* ( ) **Jalando**/*Pulling* ( ) **Manejando** /*Driving*
( ) **Levantando algo**/*Lifting* ( ) **Alsando las Manos**/*Reaching Overhead* ( ) **Tosiendo**/*Coughing* ( ) **Estornudado**/*Sneezing*
( ) **Caminar en piso disparejo**/*Walking on uneven ground* ( ) **Cambios de clima** /*Climate changes* ( ) **Otro**/*Other* _____

( ) **Tiene problemas buscando una posición confortable al dormir por el dolor?** (**Su cama es...** ( ) **Suave** ( ) **Dura** ( ) **Firme**
(Unable to find a comfortable position in bed due to pain...) *(Patients bed is... (Soft) (Hard) (Firm)*

Cuanto tiempo puede durar sentado, de pie o caminando antes de cambiar de posicion por el dolor? _____
(How long can patient sit, stand, or walk before changing positions?)

_____

Antes de el accidente, describe la capacidad de levanter cosas: _____
(Describe patient's pre-injury capacity for lifting)

Los sintomas originales han ( ) **Mejorado** ( ) **Permanesen igual** ( ) **Empeoraron**
Have original symptoms *(Improved)* *(Remained the same)* *(Worsened)*

Usando la escala, circule la intensidad de dolor que siente/*Using the following scale, circle the patient's average pain level:*

No tiene Dolor (*No Pain*)	**Pequeño** (*Minimal*)	**Poco** (*Slight*)	**Moderado** (*Moderate*)	**Severo** (*Severo*)
0	1 2 3	4 5	6 7	8 9 10

ACCIDENTES ANTERIORES/ ANTECEDENTES MEDICOS. *(Past medical history/Prior Accidents)*

Alergias *(Allergies)*: ( ) **NO** ( ) **SI** **De Que** *(To what)*? _____

Trauma Abdominal *(Abdominal Trauma)*	( )NO	( )SI	**SE RECUPERO?** *(If yes, did you fully recover?)*	( )NO	( )SI
Trauma al Pecho *(Chest Trauma)*	( )NO	( )SI	**SE RECUPERO?** *(If yes, did you fully recover?)*	( )NO	( )SI
Fracturas *(Fractures)*	( )NO	( )SI	**SE RECUPERO?** *(If yes, did you fully recover?)*	( )NO	( )SI
Trauma de Cabesa *(Head Trauma)*	( )NO	( )SI	**SE RECUPERO?** *(If yes, did you fully recover?)*	( )NO	( )SI
Otro*(Other)*	( )NO	( )SI	**SE RECUPERO?** *(If yes, did you fully recover?)*	( )NO	( )SI

SIDA/VIH *(AIDS/HIV)*	( )NO	( )SI	**Tratamiento** *(Treatment)* _____
Artritis *(Arthritis)*	( )NO	( )SI	**Tratamiento** *(Treatment)* _____
Asma *(Asthma)*	( )NO	( )SI	**Tratamiento** *(Treatment)* _____
Bronquitis *(Bronchitis)*	( )NO	( )SI	**Tratamiento** *(Treatment)* _____
Cancer *(Cancer)*	( )NO	( )SI	**Tratamiento** *(Treatment)* _____
Diabetes *(Diabetes)*	( )NO	( )SI	**Tratamiento** *(Treatment)* _____
Enfermedad cardiaca *(Heart Disease)*	( )NO	( )SI	**Tratamiento** *(Treatment)* _____
Hepatitis *(Hepatitis)*	( )NO	( )SI	**Tratamiento** *(Treatment)* _____
Alta Presion Sanguinea*(High Blood Pressure)*	( )NO	( )SI	**Tratamiento** *(Treatment)* _____
Neumonia *(Pneumonia)*	( )NO	( )SI	**Tratamiento** *(Treatment)* _____
Problemas psiquiatricos *(Psychiatric Problems)*	( )NO	( )SI	**Tratamiento** *(Treatment)* _____
Tuberculosis *(Tuberculosis)*	( )NO	( )SI	**Tratamiento** *(Treatment)* _____
Otro *(Other)*_____	( )NO	( )SI	**Tratamiento** *(Treatment)* _____

ANTECEDENTES QUIRURGICOS. *(Surgical History)*

Apendicectomia *(Appendectomy)*	( )NO	( )SI,	**Fecha** *(Date):* _____
Vesicula biliar *(Gallbladder)*	( )NO	( )SI,	**Fecha** *(Date):* _____
Hernia *(Herniotomy)*	( )NO	( )SI,	**Fecha** *(Date):* _____
Histerectomia*(Hysterectomy)*	( )NO	( )SI,	**Fecha** *(Date):* _____
De Corazon Abierto *(Open Heart/Bypass)*	( )NO	( )SI,	**Fecha** *(Date):* _____
Tonsillectomy *(Tonsillectomy)*	( )NO	( )SI,	**Fecha** *(Date):* _____
Tubal Ligation *(Tubal ligation)*	( )NO	( )SI,	**Fecha** *(Date):* _____
Otro (explicar)*/other (specify)*	( )NO	( )SI,	**Fecha** *(Date):* _____

Que medicamento esta tomamdo: *(Medications currently taking):*

Nombre/Medicamento *(Medication Name)*	**Fuerza** *(Strength) (mg/gm)*	**Dosis por dia** *(Daily Dosage)*	**Por quanto tiempo** *(Length taken)*

Accidentes o Heridas Anteriores: *(Previous Accidents/Injuries)*

( ) **Accidente de Auto***/Car accident* ( ) **Caida y resbalo** */Slip and Fall* ( ) **DeTrabajo***/Work-related*

( ) **Otro/ (Explicar)***/Other (Explain)*_____

Fecha Y Descripcion de accidente(s): _____
(Date & Description of prior accident(s))

HISTORIA SOCIAL/*SOCIAL HISTORY*

Consumo de Alcol: ( ) **Diario** ( ) **Cada Semana** ( ) **De vez en cuando** ( ) **Socialmente** ( ) **Raramente** ( ) **Nunca**
(Alcohol Intake :) *(Daily)* *(Weekly)* *(Occasionally)* *(Socially)* *(Seldom)* *(Never)*

Consumo de Tabacco: ( ) **No Fumo** ( ) **Fumo** ____ **paquete(s) por/** ( ) **Dia** ( ) **Semana** ( ) **Mes** ( ) **POR** ____ **Años**
(Tobacco Use :) *(Non-Smoker)* *(Smoker packs per...)* *(Day)* *(Week)* *(Month)* *(for)years).*

MUJERES SOLAMENTE: **Embarazada?** ( ) **NO** ( ) **SI***/yes* **(Si, quanto tiempo?** _____)
(FOR WOMEN ONLY): *(Pregnant?)* *(Yes, How long?)*

Fecha de la ultima Menstruacion/ *Date of last menstrual period*_____

LA CHIROPRACTIC CLINIC

8711 Venice Blvd, Suite A. • Los Angeles, CA 90034 • P: (562) 262-2225 • F: (424) 204-0425 • E: Tyler@sanpedrocc.com

Attorney Information

Informacion De Du Abogado

Attorney's Name_____

Nombre del abogado

Name of assistant handling your case_____

Nombre de la asistente encargada de su caso

Address_____

Dirrecion

Phone #_____

 # De telefono

Fax #_____

 # De fax

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Informed Consent for Care

Please read and sign below:

I, as a patient coming to Los Angeles Chiropractic Clinic, give the doctors permission and consent to care for myself in accordance with appropriate testing, diagnosis, and treatment. The clinical procedures in this office are typically beneficial and rarely have side effects or risks. However, although rare, medical treatments, chiropractic, physical therapy and other treatments do carry a small risk with treatment, including but not limited to: swelling, disc injuries, muscle aches, stroke, and sprains/strains.

I do not expect the doctor to be able to anticipate and explain all risk and complications. I wish to rely on the doctor to exercise judgment during the course of the procedures, which the doctors feel at the time, based on the facts then known, are in my best interest. We use all precautions (exams, x-rays) and gentle treatment procedures to mitigate risk. We cater the care plans to your individual needs.

This office does not perform breast, pelvic, prostate, rectal, or full skin evaluations. We also do not provide care for conditions (such as high blood pressure, diabetes, high cholesterol, etc.) other than those addressed in your treatment care plan. Treatment for conditions other those being addressed in our office should be performed by your family physician, or other specialist/provider. We do not prescribe or refill any controlled substances; this aspect should be taken care of by your primary care physician or the original prescriber. The patient assumes all responsibility/liability if the patient does not report on any health forms any past medical history, illnesses, medications, or allergies.

I have read, or have had read to me, the above consent. By signing below, I agree to the above, and allow the chiropractors/providers affiliated with Los Angeles Chiropractic Clinic to perform treatment procedures and protocols. I intend for this consent to cover the entire course of treatment for my present condition and any further condition(s) for which I seek treatment for in this office.

_____ _____

Patient name (Print) Date

_____

Patient (or guardian) signature

Privacy Policy Statement

By signing this document, I acknowledge that I have received/read a copy of Los Angeles Chiropractic Clinic's privacy policy. I also acknowledge that I can request a copy of the privacy policy at any time, as well as read the one posted in this office.

_____ _____

Patient name (Print) Date

_____

Patient (or guardian) signature

Personal Medical Information Consent Form

The Health Insurance Portability Accountability Act of 1996 (HIPAA) requires that we receive your permission before we use the personal information in your medical records for any reason.

This consent form gives us permission to use your Protected Health Information (PHI) to carry out treatment, receive and/or as part of health care operations of our practice.

HIPPA also requires us to have a written notice of our privacy policy describing how medical information about you may be used and disclosed. If you so desire, this written notice is available at the front desk for you to read.

You have the right to revoke, in writing, this consent form at the time, although any services performed prior to the revocation of this consent are covered by this consent.

Patient Signature: _____ **Date:** _____

Restrictions:

Right to revise Privacy Practices: As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our office's and practice may be required by changes in federal and state laws and regulations. Upon receipt, we will provide you with the most recent notice on an office visit. The revised policies and practices will be applied to all protected health information we maintain.

Doctor/Staff Signature: _____ **Date:** _____

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NOTICE OF DOCTORS LIEN

Patient: _____ Date of Accident: _____

I do hereby authorize the doctors practicing at Los Angeles Chiropractic Clinic to furnish you, my attorney, with a full report of his/her examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was recently involved.

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing him/her for the medical service rendered me both by reason of this accident and by reason of any other bills that are due his/her office and to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect and fully compensate said doctor. And I hereby further give a lien on my case to said doctor against any and all proceeds of my settlement, judgment, or verdict which be paid to you, my attorney, or myself, as the result of the injuries for which I have been treated or injuries in connection therewith.

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

I agree to promptly notify said doctor of any change or addition of attorney(s) used by me in connection with this accident, and I instruct my attorney to do the same and to promptly deliver a copy of this lien to any such substituted attorney(s).

Please acknowledge this letter by signing below and returning to the doctor's office. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment and may declare the entire balance due and payable.

_____ _____

DATED PATIENT'S SIGNATURE

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment, or verdict, as may be necessary to adequately protect and fully compensate said doctor above-named. Attorney further agrees that in the event this lien is litigated, that the prevailing party will be awarded attorney fees and costs.

_____ _____

DATED ATTORNEY SIGNATURE

Los Angeles Chiropractic Clinic Record Release

8711 Venice Blvd, Suite A, Los Angeles, CA 90034
phone: (562) 262-2225 fax: (424) 204-0425

Dr. Ramin Eshghi, DC. Dr. Tyler Clark, DC

AUTHORIZATION TO RELEASE MEDICAL RECORDS

To: _____

Address: _____

I, _____ Birth Date: _____request the following information:

X-Rays History Records Diagnosis Reports Treatment

Concerning my: Illness Accident Injury Other_____

D.O.I:_____

To be released to: Los Angeles Chiropractic Clinic, at the above address.

For the purpose of: Review and Treatment

I understand that I have a right to receive a copy of this authorization upon my request.

Signature: _____ Date: _____

Patient Spouse Parent Guardian