Auto/Work Comp/P.I. INTAKE FORM

Patient's Name: _____

Name of Insurance Company: _____

Claims Mailing Address: _____

Claim number: _____

Claim Adjustor Name: _____ Phone# _____

Name of Policy Holder: _____

Address/Location where accident occurred: _____

PATIENT/PHYSICIAN CONTRACT

I hereby authorize AcuCare Total Health and/or its agents or employees to contact my insurance company or other responsible third-party to confirm my eligibility for reimbursement for services provided by AcuCare. I understand and agree that AcuCare will provide treatment options, based upon my injuries, with varying costs per treatment, therefore, regardless of any reimbursement arrangements between myself and any insurance plan or any other third-party involved in payments for my case, payment in full for all such services is my own responsibility. In addition, I authorize any such insurance company or any other third-party to pay benefits directly to AcuCare for any outstanding balance. Furthermore, I agree to the following: 1) remit directly to AcuCare, immediately upon request, any and all amounts due or payments the insurance company paid to me instead of AcuCare for services rendered; 2) if I fail to do so, I will be responsible for reasonable attorney's fees should legal collection proceedings be initiated; 3) in the event I discontinue care on my own, I will be responsible for payment in full, any charges due AcuCare.

> NOTE: **If your private insurance carrier or health plan doesn't pay for services rendered, you are responsible to pay**. Your private insurance carrier or health plan may not pay for everything, even some care that you and/or your health care provider have good reason to think you need. Your private insurance carrier or health plan may not pay for the following but not limited to: Massage Therapy, Manual Therapy, Laser Therapy, or SpineMed aka spinal decompression.

I certify that all of the above information is current, true and correct to the best of my knowledge, and I will notify this office immediately of any changes in my health status or financial information. I also understand that even though I am using insurance all services are ultimately my responsibility.

Patient Signature: _____

Date: _____

ACCIDENT AND INJURY QUESTIONNAIRE AND ASSIGNMENT

Date of Injury: _____ Time of Injury: _____

Type of Accident or Injury: __ Auto __ Work Related ___Other (specify)_____

Where did the accident occur? _____

Describe how it happened:

_____

_____

_____

If an auto accident:

Were you __driver __ passenger __ pedestrian ___other _____

Did your care strike the other? __ Yes __ No

Did the other car strike yours? __ Yes __ No

Collision occurred from: __ backend __ front __ left __ right

Were traffic citations issued to: __ you __driver of your car __ driver of other car __ none

Have you contacted an attorney? __Yes __No

Name_____ Phone: _____

If a work injury:

Employer's Name: _____

Employer's Address: _____

Contact Name & Phone Number: _____

Did you report this to your employer? __ Yes __ No

Did they recommend care at our office? __ Yes __ No

Describe in detail, any symptoms immediately following the accident/injury.

_____

_____

Have you had any of these symptoms before? __Yes __No If so, which ones? _____

_____

Have you had a previous injury to the presently injured area? __Yes __ No

If YES, how did it happen?_____

Have you lost any time from work? __ Yes __ No

Dates: From _____ through _____.

Were you hospitalized? __ Yes __ No If YES, where? _____

Authorization to Use or Disclose Protected Health information

ACUCARE TOTAL HEALTH

Patient Name: _____("Patient")

Address: _____

Date of Birth: _____ Today's Date: _____

As required by the Privacy Regulations, AcuCare Total Health may not use or disclose your protected health information except as provided in our Notice of Privacy Practices without your authorization.

I hereby authorize this office and any of its employees to use or disclose my Patient Health Information to the following person(s), entity(s), or associates of this office and :

- my attorney and/or insurance company

Patient Health Information authorized to be disclosed:

- for this injury only unless approved by the patient.

For the specific purpose of:

- treatment and payment.

Effective dates for this authorization will be from the beginning of therapy for the accident and expire on the last therapy date. I understand that the information disclosed above may be re-disclosed to additional parties and no longer protected for reason beyond our control.

I understand I have the right to:

1. Revoke this authorization by sending written notice to this office and that revocation will not affect this office's previous reliance on the uses or disclosure pursuant to this authorization.
2. Knowledge of any remuneration involved due to any marketing activity as allowed by this authorization, and as a result of this authorization.
3. Inspect a copy of Patient Health Information being used or disclosed under federal law.
4. Refuse to sign this authorization.
5. Receive a copy of this authorization.
6. Restrict what is disclosed with this authorization.

I hereby acknowledge that if I choose to not sign this Authorization, my course of treatment will not alter nor will payment, enrollment in a health plan, or eligibility for benefits will be altered or my patient health information disclosed. *

_____ _____

Signature of Patient or Patient's Authorized Representative Date

_____ _____

Authorized Signature of Facility Date

*Terms and conditions apply. See next page for details.

Terms and Conditions

1. Any waiver by either party of a breach of any provision of this Agreement shall not operate as, nor be construed to be, a waiver of any subsequent breach. No delay or omission in the exercise or enforcement of any right or remedy provided in this Agreement or by law by either party shall be construed as a waiver of such right or remedy.

2. If any clause, phrase, provision or portion of this Agreement, or the application thereof to any person or circumstance, shall be declared invalid or unenforceable under applicable law, such event shall not affect, impair or render invalid or unenforceable the remainder of this Agreement, or any other clause, phrase, provision or portion hereof, nor shall it affect the application of any clause, phrase, provision or portion hereof to other persons or circumstances.

3. Neither party may assign this Agreement without the prior written consent of the other.

4. This Agreement shall be governed by and interpreted in accordance with the laws of the State of Illinois. Venue and jurisdiction for any litigation arising out of this Agreement shall vest exclusively in the Circuit Court for the Sixteenth Judicial Circuit, Kane County, Illinois.

5. Any notice under this Agreement shall be sufficiently given if delivered in person, by electronic mail, by registered or certified mail, postage prepaid, or by a recognized delivery service, using the most recent contact information provided by the recipient, and such notice shall be deemed to have been given when so delivered, sent by electronic mail, or mailed.

6. This Agreement contains and constitutes the entire understanding and agreement between the parties hereto with respect to the subject matter of this Agreement, and supersedes and cancels all previous negotiations, agreements, commitments, and writings relating to the subject matter. It may be amended only by an agreement in writing, signed by each of the parties hereto.

7. Wherever used in this Agreement, the singular shall include the plural, the plural shall include the singular, and pronouns shall be read as masculine, feminine or neuter as the context requires.

8. Patient agrees to defend, indemnify and hold AcuCare and its affiliates, employees, interns, and agents harmless from and against, any claims, losses, liabilities, damages, costs and expenses including reasonable attorneys' fees arising out of or relating to Patient's breach or alleged breach of any warranty or other provision of this Agreement, or any other negligent or wrongful act or omission of Patient. Patient shall not be obliged to pay or indemnify any settlement amount unless Patient has consented to the settlement.

9. In the event that a dispute arises between Patient and AcuCare regarding the total cost of care for Patient, Patient hereby agrees to hold any settlement proceeds ("Proceeds") in escrow until such time as an agreement, signed by all parties, is thereby executed. Furthermore, Patient agrees that AcuCare shall have lien upon such Proceeds until such a time as the agreement can be reached. In the event an agreement is not reached, AcuCare shall be entitled to the outstanding balance due and owing and shall be paid from the Proceeds within a reasonable time, but not to exceed thirty (30) days from the date AcuCare provides written demand to Patient.