CAVE SPRINGS CHIROPRACTIC

DR. TERRY A. SURTIN
4127 MEXICO ROAD ST. PETERS, MO 63376
(636)441-5700 FAX(636)441-7784

DOCTORS LIEN, HEALTH REPORTS AND PAYMENT RESPONSIBILITY

Patient Information:

Name: **File Number:**

Address: **Social Security:**

City/State/Zip: **DOB:**

Phone:

I hereby authorize and direct you, my attorney and/or insurance company, to **pay directly to Cave Springs Chiropractic** – Terry A. Surtin, D.C. P.C. such sums as may be due and owing him for professional services rendered me both by reason of this illness or accident and by reason of any other bills that are due his office and to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect said doctor. ***I hereby further give a lien*** on my case to said doctor against any and all proceeds of any settlement, judgement, or verdict which may be paid to my attorney, or myself as the result of the illness or injuries for which I have been treated or injuries in connections therewith.

I hereby authorize **Cave Springs Chiropractic** – Terry A. Surtin, D.C. P.C to furnish you, my attorney and/or insurance company, with a full report of his examination, diagnosis, treatment, prognosis, etc., of myself in regard to the illness or injury in which I was involved.

I fully understand that I am directly and ***fully responsible*** to Cave Springs Chiropractic – Terry A. Surtin, D.C. P.C. **for all medical bills submitted by him for services rendered to me** and that this agreement is made solely for his/her additional protection and in consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, judgement, or verdict by which I may eventually recover said fees. I also understand that any insurance filed on behalf of myself by **Cave Springs Chiropractic** is strictly a courtesy and I am the responsible for monies owing this office. I further agree to pay all cost, attorneys' fees and collection fees that **Cave Springs Chiropractic** may incur in attempting to recover payment of money I owe pursuant to this agreement, and to pay 9% interest on all sums outstanding more than 30 days.

Patient's signature_____ Date_____

Print patient's name_____

The undersigned, being attorney of record for the above patient does hereby agree to observe all the terms of this above and agrees to withhold such sums form any settlement, judgment, or verdict as may be necessary to protect Dr. Surtin.

Attorney's signature_____ Date _____

Attorney: Please sign, date and return the original to the doctor's office at once. Please keep a copy for your records.

CAVE SPRINGS CHIROPRATIC

HISTORY AND CONSULTATION

PATIENT:_____ Date:_____ Age:_____ Sex:_____

O-Onset
(When and How)

P-Palliative
(Any make you feel better? Including medications?)

P-Provocative
(Any make you feel worse? Certain movements?)

Q-Quality
(Sharp, dull, stabbing, aching.....)

R-Radiation/Referral
(Does the pain go to other parts of the body?)

S-Severity/Site
(Scale from 1 to 10, 10 being worst)

T-Timing
(Worse in the morning or evening?)

Past history of present complaint.