ALL BROWARD
Chiropractic and Pain Rehab. Center, Inc.

Dr. Michael Surdis Jr, D.C.
7900 NW. 33rd Street, #104
Hollywood, FL 33024
954-443-2420 • Fax 954-443-8422

Personal Injury Intake Form and Chiropractic Care Agreement

Patient Information:

Today's Date _____ Cell Phone _____
Name _____ Work Phone _____
I prefer to be called _____ Email _____
Address _____ Social Security # _____
_____ Date of Birth _____
_____ Height ____'____" Weight ____ lbs.
Sex Male ☐ Female ☐
Occupation _____ Marital Status _____
Employer _____ No. of Children _____
Address _____
If Minor, name of parent or guardian _____
Who should we contact in case of an emergency? _____
Relation _____ Phone _____
Address _____
Attorney _____ Phone _____
Primary Care Physician _____ Phone _____
How did you hear about our office? _____
Have you ever been to a chiropractor before? **YES** ☐ **NO** ☐ If so, whom? _____

Health Insurance Information:

Insurance Company _____ Policy Number _____
Policy Holder's Name _____ Social Security # _____
Address _____ Phone _____
_____

Auto Insurance Information:

Insurance Company _____ Policy Number _____
Address _____ Phone _____
Adjustor _____ Claim # _____

Accident Information:

Date _____ Time _____AM PM Was it reported to the police? **YES** ☐ **NO** ☐
Was a traffic violation issued? **YES** ☐ **NO** ☐ To whom? _____
Location of accident (Street, Town) _____ # of other passengers ___

Please list any past motor vehicle accidents or traumas and dates _____

_____

Is there anything else about your health history or family health history that you feel is important to share? _____

_____

Do you exercise? ☐ **YES** ☐ **NO**
Are you on a special diet? ☐ **YES** ☐ **NO** Since: ____/____/____
Do you smoke? ☐ **YES** ☐ **NO** How much? _____ How long? _____
Are you wearing: ☐ **ORTHOTICS** ☐ **HEEL LIFTS** ☐ **ARCH SUPPORTS**

For women: Are you taking birth control? ☐ **YES** ☐ **NO**
Are you pregnant? ☐ **YES** ☐ **NO** How long? _____ Nursing? ☐ **YES** ☐ **NO**

Authorization

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the doctor to help determine appropriate treatment. If there is any change in my medical status, I will inform the doctor. I authorize my insurance company to pay to the doctor or medical group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges or not paid by insurance.

Patient/Legal Guardian Signature _____ **Date** _____

INITIAL EVALUATION – Automobile Accident

LAST NAME:_____ FIRST NAME:_____ MI:_____ Date: _____

What brings you into our office? ☒ **Automobile Accident**

When did this accident happen? _____

What was your position in the vehicle?

☐ Driver ☐ Front Passenger ☐ Left Rear Passenger
☐ Middle Front Passenger ☐ Middle Rear Passenger ☐ Right Rear Passenger

What was the damage to the vehicle? ☐ Mild ☐ Moderate ☐ Extensive ☐ Totaled

How was the visibility on the road? ☐ Poor ☐ Fair ☐ Good

And the weather was:

☐ Clear ☐ Raining ☐ Windy ☐ Foggy ☐ Snowing

How did the accident happen?

☐ I hit another vehicle ☐ Another vehicle hit me ☐ I hit an object

What was the point of impact on our vehicle?

☐ Left ☐ Front end ☐ Rear end ☐ Right
☐ Left front ☐ Left rear ☐ Right front ☐ Right rear

Did you see the accident coming? ☐ Yes ☐ No

Were you braced for the impact? ☐ Yes ☐ No

Were you wearing a seatbelt? ☐ Yes ☐ No

If yes, does the seatbelt have a shoulder strap? ☐ Yes ☐ No

Does your vehicle have an airbag? ☐ Yes ☐ No

Did it deploy during the accident? ☐ Yes ☐ No

Does your vehicle have headrests? ☐ Yes ☐ No

What is the position of the headrest: ☐ Even with top of my head
☐ Even with bottom of my head
☐ Middle of neck

Did you strike anything inside the vehicle? ☐ Yes ☐ No

INITIAL EVALUATION – Automobile Accident

What inside your vehicle did you strike?

☐ Airbag	☐ Armrest	☐ Center Console	☐ Dashboard	☐ Gear shift lever/knob
☐ Headrest	☐ Rearview mirror	☐ Roof	☐ Rear window	☐ Seatback
☐ Side door	☐ Side window	☐ Wheel	☐ Windshield	
☐ Other:_____				

Immediately after the accident, did you feel dazed? ☐ Yes ☐ No

Did you lose consciousness? ☐ Yes ☐ No

Which way was your head turned during the accident?
☐ Facing straight forward ☐ Turned to the right ☐ Turned to the left

Was your head injured? ☐ Yes ☐ No

Immediately after the accident, did you experience: ☐ Headache ☐ Neck Pain ☐ Low Back Pain

Did you see another doctor before coming here? ☐ Yes ☐ No

Did you go to a hospital after the accident? ☐ Yes ☐ No If yes, which hospital? _

How did you get to the hospital? ☐ Ambulance ☐ Drove self ☐ Somebody else ☐ Police

Were any of the following tests performed at the hospital?
☐ X-Rays ☐ MRI ☐ CT Scan ☐ Lab Work

Do you feel your condition is: ☐ Improving ☐ Staying the same ☐ Getting worse

Have you lost time from work? ☐ Yes ☐ No

Can you perform physical work activities: ☐ Yes ☐ No
If no, because of: ☐ Pain ☐ Weakness ☐ Stress

Can you go to sleep without problems? ☐ Yes ☐ No

Do you awaken because of pain? ☐ Yes ☐ No

Did you have sleep problems before? ☐ Yes ☐ No

Activities of Daily Living — Please select all activities which you are currently experiencing problems:

☐ Seeing	☐ Tasting	☐ Smelling	☐ Eating	☐ Hearing	☐ Insomnia
☐ Dressing	☐ Reading	☐ Typing	☐ Writing	☐ Grasping	☐ Using the toilet
☐ Standing	☐ Leaning	☐ Walking	☐ Stooping	☐ Squatting	☐ Loss of sexual drive
☐ Bending	☐ Twisting	☐ Carrying	☐ Lifting	☐ Pushing	☐ Restful sleeping
☐ Sitting	☐ Driving	☐ Sports	☐ Exercising	☐ Reclining	☐ Loss of concentration
☐ Irritable	☐ Riding in car	☐ Air travel	☐ Climbing	☐ Pulling	☐ Changes in personality
☐ Grooming	☐ Pinching	☐ Kneeling	☐ Reaching	☐ Nervous	☐ Tactile feeling

INITIAL EVALUATION – Automobile Accident

☐ Bathing ☐ Holding

Past Medical History Please select all conditions that you have had or are currently having:

☐ None	☐ Other	☐ Abdominal pain	☐ Weight gain/loss	☐ Angina
☐ Anorexia	☐ Anxiety	☐ Aortic aneurysm	☐ Arthritis	☐ Asthma
☐ Bladder infection	☐ Blood disorder	☐ Breast lumps	☐ Breast soreness	☐ Bronchitis
☐ Cancer	☐ Cardiovascular Dx	☐ Chest pain	☐ Chronic cough	☐ Chronic sinusitis
☐ Colitis	☐ Constipation	☐ Convulsions	☐ COPD	☐ Depression
☐ Dermatitis, Eczema/Rash	☐ Diabetes	☐ Difficulty in swallowing	☐ Dizziness	☐ Emphysema
☐ Endometriosis	☐ Epilepsy	☐ Excessive thirst	☐ Fainting	☐ Frequent urination
☐ General fatigue	☐ Gout	☐ Hand pain	☐ Headache	☐ Heart attack
☐ Heart disease	☐ Heartburn/Indigestion	☐ Hepatitis	☐ High Blood Pressure	☐ High cholesterol
☐ High PSA	☐ High triglycerides	☐ Hypertension	☐ Irregular menstrual flow	☐ Irritable colon
☐ Jaw pain	☐ Kidney disorders	☐ Kidney stones	☐ Liver / Gallbladder Problems	☐ Loss of appetite
☐ Loss of bladder control	☐ Low back pain	☐ Lung disease	☐ Mental Disease	☐ Mid back pain
☐ Muscular in coordination	☐ Neck pain	☐ Osteoarthritis	☐ Pain in ankle or foot	☐ Pain in lower leg or knee
☐ Pain in upper arm or elbow	☐ Pain in upper leg and hip	☐ Painful urination	☐ PMS	☐ Pneumonia
☐ Profuse menstrual flow	☐ Prostate problems	☐ Rapid heartbeat	☐ Renal disease	☐ Rheumatiod arthritis
☐ Scoliosis	☐ Shoulder pain	☐ Stroke	☐ Swelling/stiffness joints	☐ Thyroid disease of
☐ Tinnitus/ ear noises	Tuberculosis	☐ Tumor	☐ Ulcer	☐ Visual disturbances
☐ Wrist pain				

INITIAL EVALUATION – Automobile Accident

Family History Please select all conditions that run in your family:

☐ None	☐ Other	☐ Abdominal pain	☐ Weight Gain/loss	☐ Angina
☐ Anorexia	☐ Anxiety	☐ Aortic aneurysm	☐ Arthritis	☐ Asthma
☐ Bladder infection	☐ Blood disorder	☐ Breast lumps	☐ Breast soreness	☐ Bronchitis
☐ Cancer	☐ Cardiovascular Dx	☐ Chest pain	☐ Chronic cough	☐ Chronic Sinusitis
☐ Colitis	☐ Constipation	☐ Convulsions	☐ COPD	☐ Depression
☐ Dermatitis, Eczema/Rash	☐ Diabetes	☐ Difficulty swallowing	☐ Dizziness	☐ Emphysema
☐ Endometriosis	☐ Epilepsy	☐ Excessive thirst	☐ Fainting	☐ Frequent urination
☐ General fatigue	☐ Gout	☐ Hand pain	☐ Headache	☐ Heart attack
☐ Heart disease	☐ Heartburn/Indigestion	☐ Hepatitis	☐ HBP	☐ High cholesterol
☐ High PSA	☐ High triglycerides	☐ Hypertension	☐ Irregular menstrual flow	☐ Irritable colon
☐ Jaw pain	☐ Kidney disorders	☐ Kidney stones	☐ Liver/Gallbladder problems	☐ Loss of appetite
☐ Loss of bladder control	☐ Low back pain	☐ Lung disease	☐ Mental disease	☐ Mid back pain
☐ Muscular coordination	☐ Neck pain	☐ Osteoarthritis	☐ Pain in ankle or foot	☐ Pain in lower leg or knee
☐ Pain in upper arm or elbow	☐ Pain in upper leg and hip	☐ Painful urination	☐ PMS	☐ Pneumonia
☐ Profuse menstrual flow	☐ Prostate problems	☐ Rapid heartbeat	☐ Renal Dx	☐ Rheumatoid arthritis
☐ Scoliosis	☐ Shoulder pain	☐ Stroke	☐ Swelling/stiffness of joints	☐ Thyroid disease
☐ Tinnitus/ ear noises	☐ Tuberculosis	☐ Tumor	☐ Ulcer	☐ Visual disturbances
	☐ Wrist pain			

INITIAL EVALUATION – Automobile Accident

Surgical History Please select all surgeries that you have had in the past.

☐ None	☐ Other	☐ Abdominal Exploration	☐ Abdominoplasty	☐ Abortion
☐ ACL Reconstruction	☐ Adenoid Removal	☐ Angioplasty	☐ Appendectomy	☐ Bone Fracture Repair
☐ Breast Lump Removal	☐ Bunion Removal	☐ Carotid Artery Surgery	☐ Cataract Surgery	☐ Cervical Spine Surgery
☐ Cholecystectomy	☐ Cosmetic Breast Surgery	☐ C-Section	☐ Facelift	☐ Gallbladder Removal
☐ Gastric Bypass	☐ Heart Bypass Surgery	☐ Heart Surgery	☐ Hemorrhoid Surgery	☐ Hernia Repair
☐ Hip Joint Replacement	☐ Hysterectomy	☐ Kidney Transplant	☐ Knee Arthroscopy	☐ Knee Joint Replacement
☐ Knee Surgery	☐ LASIK Eye Surgery	☐ Liposuction	☐ Lumbar Spine Surgery	☐ Mastectomy
☐ Prostate Removal	☐ Rotator Cuff Surgery	☐ TMJ Surgery	☐ Tonsillectomy	☐ Vasectomy

☐ Surgical History was reviewed:
Not contributory

Medications Please select all medications that you are currently taking:

☐ None	☐ Other	☐ Analgesics	☐ Antacids	☐ Antibiotics
☐ Antihistamines	☐ Anti-Inflammatory	☐ Arthritis	☐ Aspirin	☐ Birth Control
☐ Blood Pressure	☐ Bone Density	☐ Cancer	☐ Cholesterol	☐ Daily Vitamins
☐ Diabetes	☐ Digestion	☐ Heart	☐ Muscle Relaxers	
☐ OTC	☐ Pain	☐ Steroids	☐ Thyroid	

Allergies Please select all items that you are allergic to:

☐ None	☐ Chemical	☐ Environmental	
☐ Food	☐ Medication	☐ Seasonal	☐ Other

Social History Please answer the following

☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

Do you have any children? ☐ Yes ☐ No If yes, how many? _____

Do you use: ☐ Tobacco ☐ Alcohol ☐ Coffee

DR. MICHAEL SURDIS, JR., P.A. d/b/a ALL BROWARD CHIROPRACTIC & PAIN REHABILITATION CENTERS
7900 N.W. 33rd Street Suite 104 Hollywood, FL 33024
954-443-2420 Fax 954-443-8422

ASSIGNMENT OF INSURANCE BENEFITS, RELEASE, & DEMAND

Insurer and Patient Please Carefully Read the Following in its Entirety!

I, the undersigned patient/insured knowingly, voluntarily and intentionally assign the rights and benefits of my automobile Insurance, a/k/a Personal Injury Protection (hereinafter PIP), Uninsured Motorist, and Medical Payments policy of insurance to the above health care provider. I understand it is the intention of the provider to accept this assignment of benefits in lieu of demanding payment at the time services are rendered. I understand this document will allow the provider to file suit against an insurer for payment of the insurance benefits or an explanation of benefits and to seek §627.428 damages from the insurer. If the provider's bills are applied to a deductible, I agree this will serve as a benefit to me. This assignment of benefits includes the cost of transportation, medications, supplies, overdue interest, any premium reimbursement and any potential claim for common law or statutory bad faith/unfair claims handling. If the insurer disputes the validity of this assignment of benefits then the insurer is instructed to notify the provider in writing within five days of receipt of this document. Failure to inform the provider shall result in a waiver by the insurer to contest the validity of this document. The undersigned directs the insurer to pay the health care provider the maximum amount directly without any reductions & without including the patient's name on the check. To the extent the PIP insurer contends there is a material misrepresentation on the application for insurance resulting in the policy of insurance being voided, rescinded, or canceled, I, as the named insured under said policy of insurance, hereby assign the right to receive the premiums paid for my PIP insurance to this provider and to file suit for recovery of the premiums. The insurer is directed to issue such a refund check payable to this provider only. Should the medical bills not exceed the premium refunded, then the provider is directed to mail the patient/named insured a check which represents the difference between the medical bills and the premiums paid.

Disputes: The insurer is directed by the provider and the undersigned to not issue any checks or drafts in partial settlement of a claim that contain or are accompanied by language releasing the insurer or its insured/patient from liability unless there has been a prior written signed settlement agreed to by the health provider (specifically the office manager) and the insurer as to the amount payable under the insurance policy. The insured and the provider hereby contests and objects to any reductions or partial payments. Any partial or reduced payment, regardless of the accompanying language, issued by the insurer and deposited by the provider shall be done so under protest, at the risk of the insurer, and the deposit shall not be deemed a waiver, accord, satisfaction, discharge, settlement or agreement by the provider to accept a reduced amount as payment in full. The insurer is hereby placed on notice that this provider reserves the right to seek the full amount of the bills submitted. If the PIP insurer states it can pay claims at the optional permissive fee schedule then the insurer is instructed & directed to provide this provider with a copy of the policy of insurance within 10 days. Any effort by the insurer to pay a disputed debt as full satisfaction must be mailed to the address above, after speaking with the office manager, and mailed to the attention of **Office Manager** per §673.3111.

EUOs and CMEs: If the insurer schedules a compulsory medical examination or examination under oath (hereinafter "EUO") the insurer is hereby INSTRUCTED to send a copy of said notification to this provider in advance of the notice being sent to the insured/patient. The provider or the provider's attorney is expressly authorized to appear at any EUO or CME set by the insurer. It is hereby demanded that at least 10 days prior to any CME that the insurer provide this healthcare provider with a list of exactly what exams and tests the CME doctor will perform. See Schagrin v. Nacht, 683 So.2d 1173 (Fla. 4th DCA 1996).

This assignment applies to both past and future medical expenses and is valid even if undated. A photocopy of this assignment is to be considered as valid as the original. I agree to pay any applicable deductible, co-payments, or services rendered after the policy of insurance exhausts and for any other services unrelated to the automobile accident. The health care provider is given the power of attorney to: endorse my name on any check for services rendered by the above provider; and to request and obtain a copy of any statements, examinations under oath given by patient, or to obtain medical records from other health care providers treating me for injuries connected with or related to the event which gave rise to my need for medical treatment with the above provider.

Release of information: I authorize this provider to: furnish an insurer, an insurer's intermediary, the patient's other medical providers, and the patient's attorney via mail, fax, or email, with any and all information that may be contained in the medical records; to obtain insurance coverage information (declaration sheet & policy of insurance) in writing and telephonically from the insurer; request from any insurer all explanation of benefits (EOBs) for all providers and non-redacted PIP payout sheets; obtain any written and verbal statements the patient or anyone else provided to the insurer; obtain copies of the entire claim file, the property damage file, and all medical records, including but not limited to, documents, reports, scans, notes, bills, opinions, X-rays, IMEs, and MRIs, from any other medical provider or any insurer. The provider is permitted to produce my medical records to its attorney in connection with any pending lawsuits. The insurer is directed to keep the patient's medical records from this provider private and confidential. The insurer is not authorized to provide these medical records to anyone without the patient's and the provider's prior express written permission. This medical records authorization is intended to comply with HIPAA and shall remain in effect for the duration of any lawsuits which may be filed to collect PIP benefits.

Demand: Demand is hereby made for the insurer to pay all bills within 30 days without reductions and to mail the latest non-redacted PIP payout sheet, the insurance coverage declaration sheet and the policy of insurance to the above provider within 15 days. The insurer is directed to pay the bills in the order they are received. However, if a bill from this provider and a claim from anyone else is received by the insurer on the same day the insurer is directed to not apply this provider's bill to the deductible. If a bill from this provider and claim from anyone else is received by the insurer on the same day then the insurer is directed to pay this provider first before the policy is exhausted. In the event the provider's medical bills are disputed or reduced by the insurer for any reason, or amount, the insurer is to: set aside the entire amount disputed or reduced; escrow the full amount at issue; and not pay the disputed amount to anyone or any entity, including myself, until the dispute is resolved by a Court.

Certification: I certify that: I have read and agree to the above and have asked questions regarding any provisions I did not understand; I have not been solicited or promised anything in exchange for receiving health care; I have not received any promises or guarantees from anyone as to the results that may be obtained by any treatment or service; and I agree that I shall review all medical records to insure that all treatments reflected on said records were provided and I also agree that the provider's prices are reasonable, usual and customary.

Patient's Name _____ Patient's Signature _____
(Please Print) (If patient is a minor, signature of parent/guardian)

Date _____

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Appointment/Cancellation/No Show Policy

Appointments

Office visits are by appointment only please call (954-443-2420). The receptionist may ask about the reason for your visit. This helps us schedule the doctors time more efficiently. Please arrive 10 minutes early for your appointment. Patients who are running late for any appointment, please call our office to let us know.

Cancellations

We would like to thank you for being a patient in our office. We value all our patients and strive to provide the best care possible in the most comfortable setting. Please understand that when we schedule your appointment, we are reserving time for your needs. We kindly ask that if you must change an appointment, please give us at least 24 hours' notice. This courtesy makes it possible to give your reserved time to another patient who would like it. We know that your time is valuable. When your appointment is made, a room is reserved, your records are prepared, and special instruments are readied for your visit. Except in the case of emergency treatment for another patient, you can expect us to be running on schedule. If you are unable to keep an appointment, we ask that you cancel at least 24 hours in advance. If this is not possible, call us as soon as you can so that another patient can be given your appointment time.

Missed Appointments (Non-Cancelled)

We understand that occasion missed appointments can occur for a variety of reasons. When you miss an appointment without canceling, someone else who could have been seen in your place is delayed unnecessarily. We track missed (non-cancelled) appointments. A "No Show/Late Cancellation" is defined as missing an appointment without cancelling at least 24 hours before scheduled time. There will be a charge for a missed or non-cancelled appointment, insurance will not cover charges for no show/late or cancellation fees. The $25.00 charge is in addition to any other charges you may have incurred. No refunds will be given.

Payment

Payment is due in full at the time of service, no exceptions.

Patient Name _____ Date _____

Signature _____

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Consent to Treat

I,_____authorize the performance upon myself of the following procedures(s): Ultrasound, electric muscle stimulation, traction, massage and stretching to be performed by or under the direction of All Broward Chiropractic/Dr. Michael Surdis, Jr.

I also consent to the performance of other diagnostic and therapeutic procedures in addition to or different from those stated above, whether arising from present or unforeseen conditions, that the above-named doctor, physical therapist, associates, or assistants, may consider necessary or advisable in the course of my healthcare.

The above-named doctor and/or his associates/assistants have explained the nature and have explained the nature and purpose of the procedures, possible alternatives, the risks involved, and the possibility of complications to me. I acknowledge that no guarantee or assurance have been given as to the results that may be obtained from the procedures given by the above-named doctor and/or physical therapist and/or his associates or assistants. I accept the risks and benefits and consent to treatment.

Signed: _____Date:_____

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PREGNANCY WAIVER

ON THIS DAY, IT HAS BEEN EXPLAINED TO ME THAT X-RAYS CAN BE DANGEROUS TO A PREGNANT WOMAN. TO THE BEST OF MY KNOWLEDGE, I DECREE THAT I AM NOT PREGNANT AT THIS TIME AND THAT DIAGNOSTIC X-RAYS CAN BE TAKEN AT THIS TIME.

DATE: _____
PATIENT'S SIGNATURE_____
WITNESS:_____

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TO: _____

_____

_____

RE: DOCTOR'S LIEN AND HEALTH REPORTS

I HEREBY AUTHORIZE THE ABOVE DOCTOR TO FURNISH YOU, MY ATTORNEY, WITH A FULL REPORT OF HIS EXAMINATION, DIAGNOSIS, TREATMENT, PROGNOSIS, ETC., OF MYSELF IN REGARD TO THE ACCIDENT IN WHICH I WAS INVOLVED.

I HEREBY AUTHORIZE AND DIRECT YOU, MY ATTORNEY, TO PAY DIRECTLY TO SAID DOCTOR SUCH SUMS AS MAY BE DUE AND OWING HIM FOR PROFESSIONAL SERVICES 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, JUDGEMENT OR VERDICT AS MAY BE NECESSARY ADEQUATELY TO 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 YOU, MY ATTORNEY, OR MYSELF (PATIENT) AS THE RESULT OF THE INJURIES FOR WHICH I HAVE TREATED OR INJURIES IN CONNECTION THEREWITH.

I FULLY UNDERSTAND THAT I AM DIRECTLY AND FULLY RESPONSIBLE TO SAID DOCTOR FOR ALL PROFESSIONAL BILLS SUBMITTED BY HIM/HER FOR SERVICE RENDERED ME AND THAT THIS AGREEMENT IS MADE SOLEY FOR SAID DOCTOR (S) ADDITIONAL PROTECTION AND IN CONSIDERATION OF THIS AWAITING PAYMENT. I FURTHER UNDERSTAND THAT SUCH PAYMENT IS NOT CONTINGENT ON ANY SETTLEMENT, JUDGEMENT OR VERDICT BY WHICH I MAY EVENTUALLY RECOVER SAID FEE.

DATE OF ACCIDENT _____

PATIENT'S FULL NAME _____

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, JUDGEMENT OR VERDICT AS MAY BE NECESSARY ADEQUATELY TO PROTECT THE SAID DOCTOR (S) NAMED ABOVE.

DATED _____ ATTORNEY'S SIGNATURE :_____

ATTORNEY: PLEASE DATE, SIGN AND RETURN ONE COPY TO OUR OFFICE AND RETAIN ONE COPY FOR YOUR FILES.