CONFIDENTIAL PATIENT CASE HISTORY

Please complete this questionnaire. This confidential history will be part of your permanent records. THANK YOU.

Name _____ Birthday _____ Sex ☐ M ☐ F

Address _____ City _____ Zip _____

Soc. Sec. # _____ Home Phone _____ Work Phone _____ E-Mail _____

Marital Status: ☐ M ☐ S ☐ D ☐ W Children, Ages _____ Spouse's Name _____

Occupation _____ Employer _____

Who referred you to us? _____ How else did you hear about us? _____

What is your major complaint? _____

_____

How long have you had this condition? _____

Have you had this or similar conditions in the past? _____

Do any positions make it feel worse? _____

Do any positions make it feel better? _____

Is this condition: ☐ Improved ☐ Unchanged ☐ Getting Worse

Is this condition interfering with your: ☐ Work ☐ Sleep ☐ Daily Routine Other _____

Other doctors or therapist who have treated THIS condition _____

What do you think caused this condition? _____

List surgical operations and years: _____

_____

_____

Do you have a family physician? Name _____

Medications, dosage and frequency: _____

_____

_____

Have you been in an auto accident or had any other personal injury? ☐ Y ☐ N Describe _____

_____

Signature _____ Date _____

Parent/Guardian _____ Date _____

Patient Name _____ Number _____ Date _____

Anderson Physical Medicine
11081 Antioch RD
Overland Park, KS 66210
Tax ID: 201547806

Patient Name: _____
Please read thoroughly.

FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS
To provide timely and accurate payment to APM for any services furnished the patient listed above by APM physicians and health care providers:
• I certify that the insurance information that I have provided is accurate, complete and current and that no other coverage or insurance exists.
• I assign my right to receive payment of authorized benefits to APM
• I request that payment of authorized benefits be made on my behalf to APM* for any services furnished the patient listed above by APM physicians and health care providers.
• I authorize APM to file an appeal on my behalf for any denial of payment and/or adverse benefit determination related to services and care provided.
• If my Health Insurance Plan will not direct payment to APM, I agree to forward to APM all health insurance payments which I receive for the services rendered by APM and its health care providers.
• I authorize APM or any holder of medical information about me or the patient listed above to release to my Health Insurance Plan such information needed to determine these benefits or the benefits payable for related services.

I further acknowledge and agree:
• That I am responsible for all charges for services provided to the patient listed above which are not covered by my Health Insurance Plan or for which I am responsible for payment under my Health Insurance Plan.
• That I agree to pay all charges which are not covered by my Health Insurance Plan or for which I am responsible for payment under my Health Insurance Plan.

If payment is not made as agreed, (customer, buyer, client, etc) shall be responsible for any and all interest (at 1.5% per month or 18% per annum), reasonable attorney fees, costs of collection and court costs incurred in efforts to enforce this agreement.

I, the undersigned, _____, in consideration of goods and/or services rendered pursuant to this agreement, do hereby personally, individually, and severally guarantee the full payment of all sums of money due and owing to **Anderson Physical Medicine** In addition, any sums of money that may become due and owing or past due according to the terms of this agreement; shall be my responsibility.

Name: (Print) _____ Name: (Signature) _____

Name: (Print) _____ Name: (Signature) _____

Dated: _____

Informed Consent for Examination and Treatment

I (we) hereby consent to the performance of examination and treatment on me or on _____, by the licensed doctors of chiropractic, medical doctors, and/or licensed physical therapists who may be employed by or engaged in practice in this clinic.

I have had an opportunity to discuss with the doctor(s) or other clinic personnel the nature and purpose of the different physical therapy procedures and chiropractic treatment (manipulation/adjustment). I understand that neither chiropractic nor medical treatment is an exact science and that my care may involve judgments based upon facts and information known to the doctor. The doctor uses this judgment to attempt to anticipate or explain risks and complications and an undesirable result does not necessarily indicate an error in judgment. No guarantee for results can be made or expected but rather I wish to rely on the doctor to choose and recommend a best course of treatment based upon facts known that is in my best interests.

I further understand that there are certain degrees of risk associated with chiropractic health care and physical therapy, which includes rarely, but not limited to fractures, disc injuries, strokes, and strain/sprains and am therefore willing to accept and consent to the risk associated with the care that I am about to receive.

I have read, or the above information has been explained regarding consent. I have had an opportunity to ask questions about my examination and treatment. By signing below, I agree and intend this consent form to cover the procedures prescribed for my condition and for any future conditions for which I seek treatment.

Female Patients: By my signature on this form I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this particular time. Date of last menstrual period _____.

_____ _____

Patient's Name (Print) Patient's Signature

_____ _____

Date Relationship or authority if not signed By patient

_____

Witness

NOTICE OF INFORMATION PRACTICES

Protecting the privacy of your personal health information is important to us. This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment, or practice operations will be made only after obtaining your consent. You may request restrictions on disclosures.

Disclosures of protected health information are limited to the minimum necessary for the purpose of the disclosure. This provision does not apply to the transfer of medical records for treatment.

You may inspect and receive copies of your records within 30 days a request to do so. There may be a reasonable cost-based fee for photocopying, postage and preparation.

You may request changes to your records. Our practice has the right to accept or deny your request.

We maintain a history of protected health information disclosures that is accessible to you.

In the future, we may contact you for appointment reminders, announcements, and to inform you about our practice and its staff.

Our practice is required to abide by this notice. We have the right to change this notice in the future. Any revisions will be prominently displayed in a clearly visible location in our office.

You may file a complaint about privacy violations by contacting our Office Manager.

Name _____ Phone _____

The effective date of this Notice of Information Practices is _____.

Thank you.

Patient Health Questionnaire - PHQ

ACN Group, Inc. Form PHQ-202

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ **Date** _____

1. Describe your symptoms _____

_____

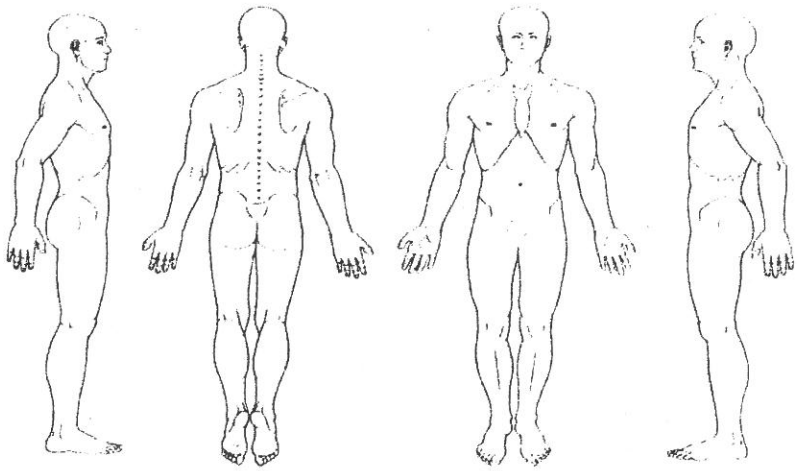
a. When did your symptoms start? _____

b. How did your symptoms begin? _____

2. How often do you experience your symptoms?

① Constantly (76-100% of the day)
② Frequently (51-75% of the day)
③ Occasionally (26-50% of the day)
④ Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms



3. What describes the nature of your symptoms?

① Sharp ④ Shooting
② Dull ache ⑤ Burning
③ Numb ⑥ Tingling

4. How are your symptoms changing?

① Getting Better
② Not Changing
③ Getting Worse

5. During the past 4 weeks:

a. Indicate the average intensity of your symptoms

None ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ Unbearable

b. How much has pain interfered with your normal work (including both work outside the home, and housework)

① Not at all ② A little bit ③ Moderately ④ Quite a bit ⑤ Extremely

6. During the past 4 weeks how much of the time has your condition interfered with your social activities?
(like visiting with friends, relatives, etc)

① All of the time ② Most of the time ③ Some of the time ④ A little of the time ⑤ None of the time

7. In general would you say your overall health right now is...

① Excellent ② Very Good ③ Good ④ Fair ⑤ Poor

---

8. Who have you seen for your symptoms?

① No One
② Other Chiropractor
③ Medical Doctor
④ Physical Therapist
⑤ Other

a. What treatment did you receive and when? _____

b. What tests have you had for your symptoms and when were they performed?

① Xrays *date:* _____ ③ CT Scan *date:* _____
② MRI *date:* _____ ④ Other *date:* _____

9. Have you had similar symptoms in the past? ① Yes ② No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

① This Office
② Other Chiropractor
③ Medical Doctor
④ Physical Therapist
⑤ Other

10. What is your occupation?

_____

① Professional/Executive
② White Collar/Secretarial
③ Tradesperson
④ Laborer
⑤ Homemaker
⑥ FT Student
⑦ Retired
⑧ Other

a. If you are not retired, a homemaker, or a student, what is your current work status?

① Full-time
② Part-time
③ Self-employed
④ Unemployed
⑤ Off work
⑥ Other

Patient Signature _____ **Date** _____

Back Index

ACN Group, Inc. Form BI-100

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ **Date**

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ The pain comes and goes and is very mild.
① The pain is mild and does not vary much.
② The pain comes and goes and is moderate.
③ The pain is moderate and does not vary much.
④ The pain comes and goes and is very severe.
⑤ The pain is very severe and does not vary much.

Sleeping

⓪ I get no pain in bed.
① I get pain in bed but it does not prevent me from sleeping well.
② Because of pain my normal sleep is reduced by less than 25%.
③ Because of pain my normal sleep is reduced by less than 50%.
④ Because of pain my normal sleep is reduced by less than 75%.
⑤ Pain prevents me from sleeping at all.

Sitting

⓪ I can sit in any chair as long as I like.
① I can only sit in my favorite chair as long as I like.
② Pain prevents me from sitting more than 1 hour.
③ Pain prevents me from sitting more than 1/2 hour.
④ Pain prevents me from sitting more than 10 minutes.
⑤ I avoid sitting because it increases pain immediately.

Standing

⓪ I can stand as long as I want without pain.
① I have some pain while standing but it does not increase with time.
② I cannot stand for longer than 1 hour without increasing pain.
③ I cannot stand for longer than 1/2 hour without increasing pain.
④ I cannot stand for longer than 10 minutes without increasing pain.
⑤ I avoid standing because it increases pain immediately.

Walking

⓪ I have no pain while walking.
① I have some pain while walking but it doesn't increase with distance.
② I cannot walk more than 1 mile without increasing pain.
③ I cannot walk more than 1/2 mile without increasing pain.
④ I cannot walk more than 1/4 mile without increasing pain.
⑤ I cannot walk at all without increasing pain.

Personal Care

⓪ I do not have to change my way of washing or dressing in order to avoid pain.
① I do not normally change my way of washing or dressing even though it causes some pain.
② Washing and dressing increases the pain but I manage not to change my way of doing it.
③ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
④ Because of the pain I am unable to do some washing and dressing without help.
⑤ Because of the pain I am unable to do any washing and dressing without help.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor.
③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
⑤ I can only lift very light weights.

Traveling

⓪ I get no pain while traveling.
① I get some pain while traveling but none of my usual forms of travel make it worse.
② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
③ I get extra pain while traveling which causes me to seek alternate forms of travel.
④ Pain restricts all forms of travel except that done while lying down.
⑤ Pain restricts all forms of travel.

Social Life

⓪ My social life is normal and gives me no extra pain.
① My social life is normal but increases the degree of pain.
② Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
③ Pain has restricted my social life and I do not go out very often.
④ Pain has restricted my social life to my home.
⑤ I have hardly any social life because of the pain.

Changing degree of pain

⓪ My pain is rapidly getting better.
① My pain fluctuates but overall is definitely getting better.
② My pain seems to be getting better but improvement is slow.
③ My pain is neither getting better or worse.
④ My pain is gradually worsening.
⑤ My pain is rapidly worsening.

Back Index Score

Neck Index

ACN Group, Inc. Form NI-100

ACN Group, Inc Use Only rev 3/27/2003

Patient Name _____ **Date**

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ I have no pain at the moment.
① The pain is very mild at the moment.
② The pain comes and goes and is moderate.
③ The pain is fairly severe at the moment.
④ The pain is very severe at the moment.
⑤ The pain is the worst imaginable at the moment.

Sleeping

⓪ I have no trouble sleeping.
① My sleep is slightly disturbed (less than 1 hour sleepless).
② My sleep is mildly disturbed (1-2 hours sleepless).
③ My sleep is moderately disturbed (2-3 hours sleepless).
④ My sleep is greatly disturbed (3-5 hours sleepless).
⑤ My sleep is completely disturbed (5-7 hours sleepless).

Reading

⓪ I can read as much as I want with no neck pain.
① I can read as much as I want with slight neck pain.
② I can read as much as I want with moderate neck pain.
③ I cannot read as much as I want because of moderate neck pain.
④ I can hardly read at all because of severe neck pain.
⑤ I cannot read at all because of neck pain.

Concentration

⓪ I can concentrate fully when I want with no difficulty.
① I can concentrate fully when I want with slight difficulty.
② I have a fair degree of difficulty concentrating when I want.
③ I have a lot of difficulty concentrating when I want.
④ I have a great deal of difficulty concentrating when I want.
⑤ I cannot concentrate at all.

Work

⓪ I can do as much work as I want.
① I can only do my usual work but no more.
② I can only do most of my usual work but no more.
③ I cannot do my usual work.
④ I can hardly do any work at all.
⑤ I cannot do any work at all.

Personal Care

⓪ I can look after myself normally without causing extra pain.
① I can look after myself normally but it causes extra pain.
② It is painful to look after myself and I am slow and careful.
③ I need some help but I manage most of my personal care.
④ I need help every day in most aspects of self care.
⑤ I do not get dressed, I wash with difficulty and stay in bed.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
④ I can only lift very light weights.
⑤ I cannot lift or carry anything at all.

Driving

⓪ I can drive my car without any neck pain.
① I can drive my car as long as I want with slight neck pain.
② I can drive my care as long as I want with moderate neck pain.
③ I cannot drive my car as long as I want because of moderate neck pain.
④ I can hardly drive at all because of severe neck pain.
⑤ I cannot drive my car at all because of neck pain.

Recreation

⓪ I am able to engage in all my recreation activities without neck pain.
① I am able to engage in all my usual recreation activities with some neck pain.
② I am able to engage in most but not all my usual recreation activities because of neck pain.
③ I am only able to engage in a few of my usual recreation activities because of neck pain.
④ I can hardly do any recreation activities because of neck pain.
⑤ I cannot do any recreation activities at all.

Headaches

⓪ I have no headaches at all.
① I have slight headaches which come infrequently.
② I have moderate headaches which come infrequently.
③ I have moderate headaches which come frequently.
④ I have severe headaches which come frequently.
⑤ I have headaches almost all the time.

Neck Index Score

ANDERSON
PHYSICAL MEDICINE

Patient Questionnaire

Please circle YES or NO to the following questions. This will aid us in completing your medical history.

_____ _____

Patient Signature Date

1. Do you suffer from neck pain, with pain in your arms or hands? YES NO
2. Do you have weakness, numbness, or burning in either your arms or your hand? YES NO
3. Do your hands or arms fall asleep? YES NO
4. Do you have reduced feeling (sensation) in your hands or arms? YES NO
5. Do you suffer from a loss of hand grip strength? YES NO
6. Do you suffer from back pain with pain in your buttocks, legs, or feet? YES NO
7. Do you have weakness, numbness, or burning in your buttocks, legs, or feet? YES NO
8. Do your legs or feet fall asleep? YES NO
9. Do you have reduced feeling (sensation) in your buttocks, legs, or feet? YES NO

MOTOR VEHICLE ACCIDENT FORM

Today's Date_____
Name _____
Date of Accident _____

INSURANCE INFORMATION:
Do you have a Medpay rider on your auto insurance policy? (Y / N)If yes, please list limits_____

If yes to Medpay, please list:

Insurance Company_____

Adjuster's name and phone number (if different from above) _____

Claim number (if different from above) _____

If fault of the accident was assigned to the other party, please list the following:

Other party's insurance company_____

Adjuster's name and phone number (if different from above) _____

Claim # (if different from above)_____

*Important: This form may be used in the determination of insurance benefits and/or litigation for compensation. It is imperative that this form be filled out completely to protect your rights of compensation.

Please CIRCLE Correct Responses

1. Were you the? Driver Front Passenger Back Passenger
2. Were you wearing? Seat Belt with shoulder harness
   Seat Belt with out shoulder harness
   No seat belt

2A. Did airbag deploy? YES NO N/A

3. What type of vehicle were you in? _____
4. What type of vehicle was the other driver in? _____
5. How fast were you going at time of impact? _____
6. How fast was the other car going? _____
7. What type of accident did you have?
   Head-on Rear-ended Broadsided
   Please explain and/or draw a diagram: _____

7A. Were you ejected from the car? YES NO

8. How much damage was done to your car?
   1. Totaled
   2. Less then $1,000
   3. Less then $500
   4. None

9. Did you hit your head? YES NO
   If so, on what? _____

10. Did you lose consciousness? YES NO
    If so, how long? _____
    a) When do you remember waking up? _____

11. Were you thrown around inside of the vehicle? YES NO
12. Did you have "whiplash" injury to your neck? YES NO
13. Did you hit your arms, legs, back, face against any object inside the car? YES NO
    If yes, please explain: _____

14. Did you have any cuts and/or bruises? YES NO
    If yes, please explain: _____

15. Were you able to walk at the scene of the accident? YES NO
16. Did you go to the hospital? YES NO
    a) If so, when? _____
    b) Where? _____
    c) How did you get there?
       Ambulance Drove myself _____ Drove me
    d) Were you kept overnight? YES NO
       If yes, how many nights? _____

17. If you didn't go to the hospital, when did you first seek medical attention? _____

    a) By whom? Emergency room DR Family DR Chiropractor
       Other: _____

18. Were X-Rays originally taken? YES NO
    If so, what areas were X-rayed? Please List:

19. Was anyone else in your car? YES NO
    a) Were they injured? YES NO
       If yes, please explain: _____

    b) Was anyone in the **other** vehicle seriously injured? YES NO
       If yes, please explain: _____

20. What were your **ORIGINAL SYMPTOMS** at the time of accident? (You may circle more then one answer.)

1. Headaches
2. Dizziness
3. Neck Pain
4. Neck and Arm Pain
5. Low Back Pain
6. Low Back and Leg Pain
7. Bleeding
8. Light Bothers Eyes
9. Shortness of breath
10. Facial Cuts
11. Facial Bruising
12. Knee Pain
13. Loss of Consciousness
14. Jaw Pain
15. Facial Pain
16. Numbness: Where_____
17. Pins and Needles: Where:_____
18. Other Symptoms:_____

please list: _____

_____

_____

21. What are you **SYMPTOMS NOW**? Please order them from ***WORST*** to least:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

22. Have you ever had any of these symptoms prior to the accident? YES NO

If yes, please explain: _____

_____

_____

_____

23. Since this accident have you had:

1. Another MVA YES NO
2. Work related injury YES NO
3. Sports related injury YES NO
4. Any new trauma of any kind YES NO
   a) Did this make your symptoms worse? YES NO
   b) If yes, please explain: _____

_____

_____

24. How long after your accident did it take for you to return to work?

1. Didn't miss any work
2. One day
3. 2-3 days
4. 1 week
5. 2-3 weeks
6. 1 month
7. 2-3 months
8. 4-5 months
9. 6 months
10. 7-12 months
11. Haven't returned to work
12. Wasn't working at the time of accident
13. Working in the home as a "house person"

25. Did you return to the same job? YES NO

If no, please explain: _____

_____

_____

_____

26. You are now working:

1. Not at all
2. Full time, no restrictions
3. Full time, limited duty
4. Part time, no restrictions: _____ hrs/week
5. Part time, limited duty: _____ hrs/week

27. Are there any other factors associated with this accident that you feel have something to do with your current medical condition? YES NO

If yes, please explain: _____

_____

28. Is there a lawsuit pending as a result of this accident? YES NO

_____

Patient's Signature

ANDERSON PHYSICAL MEDICINE, LLC.

PATIENT NAME _____ _____
PATIENT'S INITIALS

For good and valuable consideration received, I, , being the undersigned, authorize and direct you, , to pay directly to any sums as may be due and owing this chiropractic office for services rendered me, both by reason of accident, or illness and/or by reason of any other bills that are due this chiropractic office, and to withhold such sums from any disability benefits, medical payment benefits, no-fault benefits, health and/or accident benefits, workers' compensation benefits, or any other insurance benefits or reimbursement whatsoever for which you may be obligated to reimburse me, or from any settlement, judgment or verdict on my behalf as may be necessary to adequately protect said chiropractic office.

In further consideration of the above-indicated treatment, I hereby give a lien to said office against any and all insurance benefits named herein, and any and all proceeds of any settlement, judgment, or verdict, which may be owed me as a result of the injuries or illness for which I have been treated by said office. This contract is to act as an assignment of my rights and benefits to the extent of the office's charges for services provided herein.

I, the undersigned, further hereby authorize and direct my attorney, , when settlement or judgment is reached, to pay in full the chiropractic bills rendered for all treatment and services as a result of the injuries or illness for which I have been treated by said office and any other amounts which I may owe said office at that time.

In further consideration of the treatment rendered herein, I do hereby authorize the chiropractic office to furnish you, the above-indicated party, a full report of my examination, diagnosis, treatment, prognosis, chiropractic bills and any other relevant information pertaining to my treatment.

I UNDERSTAND THAT BY SIGNING THIS DOCUMENT I AM AUTHORIZING RELEASE OF REPORTS AND INFORMATION TO THE ABOVE-INDICATED PARTY, WHICH COULD INCLUDE THE RESPONSIBLE PARTY'S INSURANCE COMPANY.

Furthermore, I authorize the chiropractic office to release any information pertinent to my case to any insurance company, adjuster or attorney to facilitate collection under this assignment, lien and medical authorization.

In the event any insurance company is obligated to make payments to me upon the charges made by this office for the services rendered and refuses to make such payments, I hereby assign and transfer to this office any and

www.apmkc.com
e-mail: dra@apmkc.com
11081 ANTIOCH, OVERLAND PARK, KS 66210
913.649.4045
fax: 913.649-8407

all causes of action, claims, whether in law or equity, that I might have or that might exist in my favor against such company, and authorize this office to prosecute said cause of action either in my name or in the office's name and further authorize this chiropractic office to compromise, settle or otherwise resolve any claim or cause of action in its sole discretion herein as it relates to amounts owed this doctor.

I understand that I am directly and fully responsible to said office for all medical bills submitted by them for services rendered me and this agreement is made solely for said office's additional protection. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fees. Said medical payments are due on demand by the office. I further understand and agree that said assignment, lien and authorization do not constitute any consideration for the office to await payment and it may demand payments from me immediately upon rendering services at its option.

This agreement is irrevocable and is binding upon the heirs, executors and legal representatives of the undersigned. Wherefore, the undersigned has hereunto set his hand this _____ day of _____, 19_____.

_____

Patient

ATTORNEY ACKNOWLEDGEMENT OF ASSIGNMENT, LIEN, AND AUTHORIZATION AND RELEASE OF MEDICAL RECORDS AND INFORMATION

I, _____, attorney for the above-indicated patient hereby acknowledge receipt of the above assignment and lien and agree to protect said chiropractic office pursuant to the above-indicated terms.

DATE:_____ ATTORNEY:_____

www.apmkc.com
e-mail: dra@apmkc.com
11081 ANTIOCH, OVERLAND PARK, KS 66210
913.649.4045
fax: 913.649-8407

Anderson Physical Medicine
11081 Antioch RD
Overland Park, KS 66210
Tax ID: 201547806
913-649-4045
913-649-8407

Date: _____

I (NAME): _____ do understand that by being treated by Anderson Physical Medicine for Auto accident occurring on _____ am incurring a balance that will be negotiated by my Attorney, that I choose and retained. In the event that he/she does not negotiate enough monies to cover Anderson Physical Medicine in full, I am here by agreeing to the following:

If the abovementioned attorney does not negotiate enough monies to cover the APM account balance for the MVA above mentioned, I am herby giving APM permission to run my credit card given below for the remaining balance. I am of sound thinking and am aware that it is possible that the Attorney may or may not have negotiated enough monies after his portion is paid in full. I am providing Anderson Physical Medicine a copy of my card and am signing to authorize the debt of the reaming balance. If the credit care given happens to expire I will provide an active current card immediately.

Name printed: _____

Signature: _____

Anderson Physical Medicine representative: _____

Date: _____

Copy of credit card – below.