PATIENT FINANCIAL PROFILE

OUR OFFICE POLICY REGARDING PERSONAL INJURY INSURANCE / MED PAY

Dr. Randy Butler will be pleased to accept your personal injury insurance coverage as soon as your exact coverage is verified by the responsible party. We will file the claim forms and assist in every way we can. However, it must be understood that you are ultimately responsible for full payment of services rendered at Butler Chiropractic Clinic. We do not imply that insurance will cover all expenses.

MY INSURANCE COMPANY INFORMATION

NAME: ______________________________ CLAIM NO: ______________________DOA:________________

ADDRESS: ____

CLAIMS ADJUSTER: ______________________________ PH: __________________ FAX: __________________

Please initial in the lines provided ONLY for the statements APPLICABLE FOR YOUR CASE:

- ______ (PIP / 3rd Party) I was injured in a motor vehicle accident and this claim is being submitted through my OR a third party automobile insurance company. In the event this claim is rejected by the insurance company, I understand that I am liable for full payment of services rendered.
- ______ (PIP) I request that my automobile insurance company make the checks for billed services payable to:

Butler Chiropractic Clinic
1501 Cross Timbers Rd. Suite 200
Flower Mound, TX 75028
Phone: 972-221-7533 | Fax: 972-219-6901

- ______ (PIP / 3rd Party) I will take full responsibility to insure all outstanding debt for services rendered will be paid in full within ten days from receipt of the settlement check.
- ______ (All) I will notify this office immediately if or when I retain the counsel of an attorney and I will instruct the attorney to furnish Dr. Randy Butler with a letter of protection to protect Dr. Randy Butler's interest upon settlement.
- ______ (LOP) I have retained an attorney to handle matters involving this injury. I shall instruct my attorney to furnish your office with a letter of protection to protect Randy Butler's interest upon statement.
  Below is my attorney information:
  NAME: ______________________________ PH: ____________________ FAX: ____________________
- ______ (ALL) I fully understand that with or without an attorney I am responsible for all services rendered.

SIGN AND DATE BELOW if you agree and understand the statements initialed above:

______________________________	______________________________	____________
PRINT PATIENT FULL NAME	**PATIENT SIGNATURE**	**DATE**

Introduction Patient Case History

Today's Date: ____/____/_____

PATIENT INFORMATION

Name: *(First MI Last)* ______________________ **Preferred Name:** __________

Address: ______________________ **City:** __________ **State:** ______ **Zip:** __________

Date of Birth: __________ **Gender:** ☐ Male ☐ Female **Social Security #:** ______________

Home: ______________ **Mobile:** ______________ **Work:** ______________

Email: ______________________

Preferred Method of Contact: ☐ Text ☐ Email ☐ Phone - *Home, Mobile, or Work* ☐ Other: __________

***Referred By:** *(Name)* ______________________

☐ Family ☐ Friend ☐ Co-Worker ☐ Doctor ☐ Other: __________

Race & Ethnicity: *(Choose up to 2)*

☐ African American or Black
☐ American Indian or Alaskan Native
☐ Asian
☐ Hispanic or Latino
☐ Native Hawaiian or Other Pacific Islander
☐ White
☐ Decline

Preferred Language:

☐ English
☐ Spanish
☐ Other: __________
☐ Decline

EMERGENCY CONTACT INFORMATION

Name: *(First MI Last)* ______________________

Home: ______________ **Mobile:** ______________

Relationship:

☐ Child ☐ Parent ☐ Spouse ☐ Other: __________

Primary Care Physician: ______________________

Doctor's Phone: ______________________

FINANCIAL INFORMATION

Is today's visit the result of an accident?

☐ No ☐ Auto ☐ Work ☐ Other: __________

Will we be working with insurance? ☐ No ☐ Yes *(Details)*

Primary: ______________ *ID#:* __________

Secondary: ______________ *ID#:* __________

Where would you like statements sent?

☐ Self ☐ Other *(Details below)*

Name: ______________________

Address: ______________________

Phone: ______________ *Email:* ______________

It is Usual and Customary to Pay for Services as Rendered Unless Otherwise Arranged

Account No: __________

ACCIDENT/INJURY QUESTIONNAIRE

Name: (Last, First MI)______________________________ **Today's Date:** __________

AUTOMOBILE ACCIDENT – ADDITIONAL INFORMATION

- **Was anyone else in the vehicle with you?** ☐ No ☐ Yes - *(Number of people)* ______
- **You were?** ☐ Front seat – *Driver / Passenger* ☐ Rear Seat – Behind Driver / Middle / Behind Passenger / 2nd Row / 3rd Row
- **Name of Driver**, *if not self*: ______________ **Name of Driver of other vehicle:** ______________
- **Did airbags deploy?** ☐ No ☐ Yes **Did Police arrive?** ☐ No ☐ Yes **Using Seatbelt?** ☐ No ☐ Yes
- **Did you strike the windshield or object in car?** ☐ No ☐ Yes - *(Describe)* ______________
- **Were you knocked unconscious?** ☐ No ☐ Yes *(How long?)* ________
- **Where was your vehicle impacted?** Front / Rear / Passenger Side / Driver's Side / Other: ______________
- **Where was the other vehicle impacted?** Front / Rear / Passenger Side / Driver's Side / Other: ______________
- **Your Auto Ins:** ______________ **Policy #:** ______________ **Claim #:** ______________ **Phone #:** ______________
  Address: ______________ **City:** ______________ **State:** ______ **Zip:** ______
- **Other's Auto Ins:** ______________ **Policy #:** ______________ **Claim #:** ______________ **Phone #:** ______________
  Address: ______________ **City:** ______________ **State:** ______ **Zip:** ______

WORKER'S COMPENSATION INJURY – ADDITIONAL INFORMATION

Employer: ______________ **Occupation:** ______________ **Claim #:** ______________
Address: ______________ **City:** ______________ **State:** ______ **Zip:** ______
Contact Person: ______________ **Phone:** ______________ **Email:** ______________

GENERAL ACCIDENT/INJURY INFORMATION – *(PLEASE USE THE REVERSE SIDE OF THIS PAGE IF ADDITIONAL SPACE IS NEEDED)*

Date of Accident: ____/____/______ **Time:** ___:_____ AM / PM

Please describe the accident in as much detail as possible? ______________________________

____

____

____

Before the accident/injury:

- **Have you ever had any complaints in the involved area before?** ☐ No ☐ Yes
  - *If yes* - **Were they present at the time of the accident/injury?** ☐ No ☐ Yes
    - *If yes* - **Summarize these complaints prior to the accident:** ______________
- **Were you capable of performing all of your work activities without restriction?** ☐ No ☐ Yes

At the time of the accident/injury:

- **Did you feel pain immediately after the accident?** ☐ No ☐ Yes ☐ Later that day ☐ Next day ☐ When? __________
- **Were you taken anywhere after the accident?** ☐ No ☐ Yes ☐ Later that day ☐ Next day ☐ When? __________
  - *If yes,* **How?**______________ **Where?**______________
  - *If yes,* **Did you receive treatment?** ☐ No ☐ Yes - *(Describe)* ______________

Since the accident/injury:

- **Are your symptoms:** ☐ Improving? ☐ Getting Worse? ☐ The Same?
- **Are your work activities restricted as a result of this accident/injury?** ☐ No ☐ Yes - *(How?)* ______________
- **Have you missed any work since this accident?** ☐ No ☐ Yes - *(Dates?)* ______________
- **Have you retained an Attorney?** ☐ No ☐ Yes - Name:______________ **Phone:** ______________
  - **Address:** ______________ **City:** ______________ **State:** ______ **Zip:** ______

Patient No:

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HISTORY OF PRESENT ILLNESS

HISTORY OF PRESENT ILLNESS *(Please describe)*

Major Complaint: ______________________________

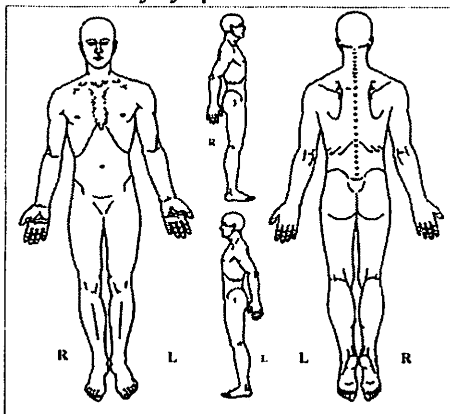
Secondary Complaints: ______________________________

When did it start? ___/___/____ **What happened?** ______________________________

Which daily activities are being affected by this condition? ______________________________

MAJOR COMPLAINT

Location of Symptoms and Radiation



P __ Pain
N __ Numb
S __ Spasm
T__ Tender
H__ Hypoesthesia

Grade Intensity/Severity:

- None (0/10)
- Mild (1-2/10)
- Mild-Moderate (2-4/10)
- Moderate (4-6/10)
- Moderate-Severe (6-8/10)
- Severe (8-10/10)

Frequency:

- Off & On
- Constant

Quality:

- Sharp
- Stabbing
- Burning
- Achy
- Dull
- Stiff & Sore
- Other: ____________

Does it radiate?

No Yes *(Please indicate on drawing)*

Improves with:

- Ice
- Heat
- Movement
- Stretching
- OTC Medications: ____________
- Other: ____________

Worsens with:

- Sitting
- Standing/Walking
- Lying Down/Sleeping
- Overuse/Lifting
- Other: ____________

Previous Treatment:

- None
- Chiropractor ____________
- Medical Doctor ____________
- Physical Therapy ____________
- ER/Urgent Care ____________
- Orthopedic ____________
- Other: ____________

Previous Diagnostic Testing:

- None
- X-rays ____________
- MRI ____________
- CT ____________
- Other: ____________

Women:** ***Are you pregnant?

No *Last Menstrual Period:* ___/___/____

Yes *Due date:* ___/___/____

Present Illness Comments:

____

Prescription Medications & Supplements: None

Yes *(List – Name, dosage, frequency)* ______________________________

Allergies to Medications: No known drug allergies

Yes *(List - Name and reaction)* ______________________________

PAST, FAMILY, AND SOCIAL HISTORY

PAST MEDICAL HISTORY

Have you *ever* had any of the following? *(Please select all that apply and use comments to elaborate.)*

Illnesses:
- ☐ Asthma
- ☐ Autoimmune Disorder (*Type*) ________
- ☐ Blood Clots
- ☐ Cancer (*Type*) ________________
- ☐ CVA/TIA (stroke)
- ☐ Diabetes
- ☐ Migraine Headaches
- ☐ Osteoporosis
- ☐ Other: ________________

____

____

Injuries:
- ☐ Back Injury
- ☐ Broken Bones
- ☐ Head Injury
- ☐ Neck Injury
- ☐ Falls
- ☐ Other: ________________

Hospitalizations: *(Non-surgical with Date)*

____

____

Surgeries: *(If yes, provide type & surgery date)*
- ☐ Cancer ________________
- ☐ Orthopedic
  - Shoulder – R / L ________
  - Elbow/Forearm – R / L ________
  - Wrist/Hand – R / L ________
  - Hip – R / L ________
  - Knee – R / L ________
  - Ankle/Foot – R / L ________
- ☐ Spinal Surgery
  - Neck: ________________
  - Back: ________________
- ☐ Other: ________________

____

____

Medical History Comments:

____

FAMILY HISTORY *(Please mark X to all that apply and use comments to elaborate.)*

☐ Unknown ☐ Unremarkable

	Mother	Father	Sibling1	Sibling2	Sibling3	Child1	Child2	Child3
Gender	F	M						
Age at death *(if Deceased)*								
Aneurysms								
CVA (Stroke)								
Cancer								
Diabetes								
Heart Disease								
Hypertension								
Other Family History								

Family History Comments:

____

SOCIAL AND OCCUPATIONAL HISTORY

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Other

Children: ☐ None ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ Other: ________________

Student Status: ☐ Full Student ☐ Part Student ☐ Non-Student

Highest level of Education: ☐ High School ☐ College Grad.

☐ Post Grad. ☐ Other: ________________

Employed: ☐ No ☐ Yes (*Occupation*) ________________

Dominant Hand: ☐ Right ☐ Left ☐ Ambidextrous

Smoking/Tobacco Use: *If current smoker, amount =* ________

☐ Every Day ☐ Some Days ☐ Former ☐ Never

Alcohol Use:

☐ Every Day ☐ Weekly ☐ Occasionally ☐ Never

Caffeine Use:

☐ Coffee ☐ Tea ☐ Energy Drinks ☐ Soda ☐ Never

Exercise frequency:

☐ Daily ☐ 3-4xs/week ☐ 2-3xs/week ☐ Rarely ☐ Never

Social History Comments: ________________

____

REVIEW OF SYSTEMS

Many of the following conditions respond to Chiropractic and Acupuncture treatment.

Are you *currently* experiencing any of these symptoms? *(Please select all that apply and use comments to elaborate.)*

Constitutional: *(General)*
- Fever
- Fatigue
- Other: ____________________
- *None in this Category*

Musculoskeletal:
- Joint Pain/Stiffness/Swelling
- Muscle Pain/Stiffness/Spasms
- Broken Bones________________
- Other: ____________________
- *None in this Category*

Neurological:
- Dizziness or Lightheaded
- Convulsions or Seizures
- Tremors
- Other: ____________________
- *None in this Category*

Psychiatric: *(Mind/Stress)*
- Nervousness/Anxiety
- Depression
- Sleep Problems
- Memory Loss or Confusion
- Other: ____________________
- *None in this Category*

Genitourinary:
- Frequent or Painful Urination
- Blood in Urine
- Incontinence or Bed Wetting
- Painful or Irregular Periods
- Other: ____________________
- *None in this Category*

Gastrointestinal:
- Loss of Appetite
- Blood in Stool or Black Stool
- Nausea or Vomiting
- Abdominal Pain
- Frequent Diarrhea
- Constipation
- Other: ____________________
- *None in this Category*

Cardiovascular & Heart:
- Chest Pains/Tightness
- Rapid or Heartbeat Changes
- Swelling of Hands, Ankles, or Feet
- Other: ____________________
- *None in this Category*

Respiratory:
- Difficulty Breathing
- Cough
- Other: ________________
- *None in this Category*

Eyes & Vision:
- Eye Pain
- Blurred or Double Vision
- Sensitivity to Light
- Other: ____________________
- *None in this Category*

Head, Ears, Nose, & Mouth/Throat:
- Frequent or Recurrent Headaches
- Ear - Ache/Ringing/Drainage
- Hearing Loss
- Sensitivity to Loud Noises
- Sinus Problems
- Sore Throat
- Other: ____________________
- *None in this Category*

Endocrine:
- Infertility
- Recent Weight Change
- Eating Disorder
- Other: ____________________
- *None in this Category*

Hematologic & Lymphatic:
- Excessive Thirst or Urination
- Cold Extremities
- Swollen Glands
- Other: ____________________
- *None in this Category*

Integumentary: *(Skin, Nails, & Breasts)*
- Rash or Itching
- Change in Skin, Hair, or Nails
- Non-healing Sores or Lesions
- Change of Appearance of a Mole
- Breast Pain, Lump, or Discharge
- Other: ____________________
- *None in this Category*

Allergic/Immunologic:
- Food Allergies
- Environmental Allergies
- Other: ____________________
- *None in this Category*

Review of Systems Comments:

____

I have answered these questions to the best of my knowledge and certify them to be true and correct.

Patient or Guardian Signature ____ Date____________________

Last updated: 11.13.24

Health Insurance Portability & Accountability Act (HIPAA) Consent Form

Your Protected Health Information (referred to as "PHI" for the remainder of this document) will be used by this office or disclosed to others for the purpose of treatment, obtaining payment, or supporting the day to day healthcare operations of this office. You should review the Notice of Privacy Practices for a more complete description of how your PHI may be used of disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may review the Notice prior to signing this consent. You may request a copy of the Notice from the Front Desk. This office reserves the right to modify the privacy practices outlined in the Notice.

Requesting a Restriction on the Use of Disclosure of Your Information

You may request a restriction on the use of disclosure of your PHI. It is the policy of this office that it will continue to provide treatment for a patient who restricts consent to the use and disclosure of his/her PHI for the purposes of treatment, payment or health care operations. Use or disclosure of protected health information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

I, ______________________ (print) acknowledge that I have reviewed the above information and give my permission to this office to use and disclose my health information in accordance with it.

I give permission for Butler Chiropractic to share my personal health information with the following persons:

Person ______________________________ Relationship ______________________________

Person ______________________________ Relationship ______________________________

You may revoke this consent to the use and disclosure of your PHI. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Patient Signature: ______________________________________ **Date:** ____________________

Assignment of Benefits

For professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. **THIS IS A DIRECT ASSIGNMENT OF PAYMENT TO BUTLER CHIROPRACTIC.** This payment will not exceed my indebtness to the above assignee and I have agreed to pay, in current manner, any balance of said professional fees for non-covered services and/or fees over and above the insurance payment or as required by my insurance policy. A photocopy of this assignment shall be considered as effective and valid as the original. I also authorize the release of any information pertinent to my claim to any insurance company, adjuster, or attorney for the purpose of securing payment under this policy of insurance.

Assignment and Conveyance of Lien Interest (LOPs/Attorney, PI, Automobile Accidents, Workers Comp, etc)

I hereby execute and provide Irrevocable Lien Interest and Assignment of Proceeds to apply to all monetary proceeds from any 3rd party liability insurance policy and/or all monetary proceeds from any PIP/Medical payment insurance policy to which I am entitled, and from which I am paid in the form of an insurance settlement(s), claim(s), judgement(s), or verdict(s) resulting from any identified accident. The Insurance Carrier is instructed that pursuant to this Irrevocable Lien Interest and Assignment of Proceeds the total dollar amount of all sums which I owe on an account to the above named doctor and treating facility by the insurance carrier out of those settlement proceeds to which I am entitled or withheld from any settlement or award to which I shall be entitled and thereafter be paid directly to the above names doctor and/or amounts are determined to be owed, due, and payable on my account to such named doctor and treating facility and remit payment of all such sums directly to such named doctor and/or treating facility upon receipt of my settlement award(s).

Patient Signature: _____________________________ **Date:** ______________________

Informed Consent to Treat

I hereby authorize and release the above named doctor and any individual in the employment of the doctor designated to administer treatment, physical examination, x-ray studies, chiropractic care, or any clinical services that he/she deems necessary to my case and plan of treatment. I understand that, as well as any healthcare procedure or treatment, that complications are possible following chiropractic manipulation and/or manual therapy techniques. The risks of complications due to chiropractic treatments have been labeled as "rare" and the probability of adverse reaction due to ancillary procedures is also considered "rare". By signing below, I acknowledge that I have read and agree to the above Consent for Treatment.

Patient Signature: _____________________________ **Date:** ________________________

Functional Rating Index

For use with **Neck and/or Back Problems**

In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities. For each item, please **circle** the number which most closely **describes your condition right now**.

1. Pain Intensity

0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping

0	1	2	3	4
Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3. Personal Care (washing, dressing, etc.)

0	1	2	3	4
No pain; no restrictions	Mild pain; no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Sitting (driving, traveling, etc.)

0	1	2	3	4
No pain after any sitting	Increased pain after several hours	Increased pain after 1 hour	Increased pain after ½ an hour	Increased pain after any sitting

5. Work (house work, garden work, etc)

0	1	2	3	4
Can do usual work plus extra work	Can do usual work no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. Recreation (golfing, pickleball, social events, etc)

0	1	2	3	4
Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities

7. Frequency of pain

0	1	2	3	4
No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day

8. Lifting

0	1	2	3	4
No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking

0	1	2	3	4
No pain; any distance	Increased pain after 1 Mile	Increased pain after ½ Mile	Increased pain after ¼ Mile	Increased pain any walking

10. Standing

0	1	2	3	4
No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after ½ an hour	Increased pain with any standing

Name: ______________________________(Printed)

Total Score: ________

Signature: ______________________________ Date: ____________

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www.chiroeveidence.com

PARTIAL ASSIGNMENT OF CAUSE OF ACTION, ASSIGNMENT OF PROCEEDS CONTRACTUAL LIEN & AUTHORIZATION

Purpose - The purpose of this assignment is to improve the ability of the Office to collect my Charges directly from various Payers. Accordingly, I agree to the following and direct all Payers as follows:

Definitions: In this Assignment the following terms shall have the following meaning: "Office" and "Clinic" shall refer to **Butler Chiropractic Clinic** "Payer" shall refer to, without limit, any insurance carrier, health benefit plan administrator, and fiduciary, health maintenance organization, preferred and independent provider organization, attorney, at fault party, individual, and any other entity which may elect or be obligated to pay or disperse Proceeds to me, either now or in the future, for any reason. "Proceeds" all include, without limit, the Proceeds from any settlement, judgment, or verdict, the Proceeds from any promise to pay or reimburse, and the Proceeds relating to the following benefits plans or coverage's, individual and group health benefits, Medicare, Medicaid, Workers Compensation, disability, liability uninsured and underinsured motorist, no fault, medical payments benefits, personal injury protection, lost wages, lost services, property damage and malpractice *regardless of whether such Proceeds relate directly to my Charges or not.* "Charges" shall include, without limit, the full fees for the Office's services (including, without limit, treatment, medical equipment, supplies, supplements, narrative reports, photocopies, depositions, and testimony), and any Collection Cost incurred by the Office, *interest and delinquency penalties to the extent permitted by law, and any other Charges incurred by me at the Office.* "Collection Cost" shall include, without limit, any pre and post judgment court cost, filing fees, services of process Charges, attorney's fees, and any other cost of collection incurred by the office in any effort or action to collect my Charges either from me or from my Payer.

Partial Assignment of the Cause of Action, Assignment of Proceeds and Contractual Lien - I hereby assign to the Office, insofar as permitted by law, but only to the extent of my Charges of all my rights, remedies, and benefits relating to any Payer including, without limit, my right to receive Proceeds from any Payer now or in the future, any and all causes of action that I might have against any Payer now or in the future, the right to prosecute such causes of action either in my name or in the Offices name, and the right to settle or otherwise resolve such causes of action as the Office sees fit. I further grant contractual lien to the office with respect to my Charges. I further intend for this Assignment to create a secured interest under the applicable Uniform Commercial Code and hereby direct the Office to file the form(s) normally filed with the Secretary of State or other governmental agency in order to perfect such lien. Consistent with these provisions, I hereby direct any and all Payers to pay the Proceeds directly to, immediately to, and exclusively in the name of the Office to the extent of my Charges.

Specific direction to Any Attorney I Retain, Such as in Accident Cases - In the event that I retain one or more attorneys to assist me in collecting Proceeds, I hereby direct (and the Office hereby request) each attorney to provide immediate notice to the Office regarding any Proceeds received by the attorney to promptly pay the Office in full out of such Proceeds and to provide a full accounting of such Proceeds to the Office. I agree that the purpose of any Proceeds received by the attorney is to pay my Charges.

Other Disclosure Authorization - I hereby direct all Payers to release to the Office any pertinent information regarding any coverage I may have including without limit the amount of coverage, the amount paid thus far, and the amount of any outstanding claims. I authorize and direct the Office to release any information regarding my treatment or pertinent to my case(s) including, without limit, a copy of my Charges and a copy of this Assignment to all Payers in order to facilitate collection of my Charges.

Miscellaneous Provisions - Except provided in the paragraph, this Assignment shall not be modified or revoked without expressed written consent of the Office. I hereby revoke with the Office consent the terms of any previously signed documents but only to the extent those terms conflict with the terms of this Assignment. I agree that each and every provision of this Assignment is reasonably necessary for the protection of the rights and interest of the Office and myself. However, should any provision of this Assignment be found invalid, illegal, or unenforceable or for any reason cease to be binding on any part hereto, all other portions and provisions of this Assignment shall nevertheless remain in full force and effect. This Assignment shall be governed under the laws of the state of Texas where the office is located and is performable in the county of Denton where the Office is located. In any action based upon this Assignment, I hereby consent to personal jurisdiction and venue of any court in said county of Denton and waive all objections based on improper jurisdiction, venue, or forum non conveniens as such term is defined by law. I further waive any statute of limitations which may apply in any action based upon this Assignment.

I have read and understand and agree to the terms of this Assignment.

Patient Name (Print):______________________________ Signature:__________________________ Date:______________

Parent/Guardian (Print):__________________________ Signature:__________________________ Date: ____________