CORE MEDICAL CENTER®
PAIN MANAGEMENT, THE WAY IT SHOULD BE

Core Medical Center 1131 w main st.
Blue Spring, MO, 6415
Ph: 816 - 229 - 1941 Fax: 816 - 229 - 7085

Core Medical Center Forms

Patient Information

Patient Name:_____ **DOB**:_____ **Gender**: ○M or○F

Address: _____ **City**:_____ **State**:_____ **Zip Code**:_____

Phone Number:_____ **Email**:_____ **Last 4 of SSN**_____

Occupation:_____ **Employer**:_____ **Phone**:_____

Marital Status: Single Married Widowed Divorced Separated **Spouse's Name**:_____

Spouse's Occupation:_____ **Spouse's Employer**:_____

Emergency Contact: _____ **Relationship:** _____ **Phone:**_____

What specific condition brought you into the office?:_____

Previous Care

What type of treatment have you received for this condition?_____

Did it resolve the condition? ○Yes ○No

Primary Care Physician's Name:_____

Clinic Name:_____

Clinic Phone Number:_____

I allow my health progression to be shared with my primary care physician: ○Yes ○No

Lifestyle History

Check Your Exercise Level:
○Inactive
○Light Activity
○Moderate Activity
○Heavy Activity
○Vigorous Activity

Please check all that apply:
☐Tobacco ☐Alcohol ☐Coffee/Caffeine Beverages
Do you currently or have previously used recreational drugs?
○Yes ○No If yes, what types/method used (IV, inhaled, etc)_____

Work Activity

Work Activity Level:
○Full-time ○Part-Time ○Homemaker ○Student ○Unemployed

If you are not working, it is due to the accident? ○Yes ○No

Have you had to decrease your work hours since the accident?
○Yes ○No ○If yes, how much?_____

Labor Activity:
○Light ○Moderate ○Heavy ○Sedentary

Work Activity Postures: (Select all that apply)

☐Bending	☐Climbing	☐Kneeling	☐Pulling
☐Pushing	☐Reaching	☐Sitting	☐Standing
☐Twisting	☐Walking	☐Computer	☐Repetitive

Medical History

Please list any previous car accidents or work injuries by approximate date. Did you completely recover?_____
_____

Please list any surgeries you have received by body part and approximate date. Did you completely recover?_____
_____

Please list current or previous medical problems not related to your accident (eg. Heart Disease, Diabetes, Cancer, High Blood Pressure, etc.)_____
_____

Please list current medications:_____
_____
_____
_____
_____

Accident History

Date of Accident:_____

Was the crash on the job? O Yes O No

Time of day: O Daylight O Dawn O Dusk O Dark

Road conditions: O Dry O Damp/Wet O Snow O Dark O Other_____

Intersection/Location of accident:_____
_____

You were: O Driver O Front Seat Passenger O Left Rear Passenger
O Right Rear Passenger O Middle Rear Passenger O Motorcycle Driver
O Motorcycle Passenger O Bicycle O Pedestrian

Were you wearing a seatbelt? O Yes O No

Type of vehicle you were traveling in? (Year, Make, Model):
_____

Your estimated speed at moment of impact? Low, medium or high?
O Stopped O Slowing O Accelerating

The impact occurred on the (check all that apply):
O Driver's Side O Passenger Side O Front O Rear

Which way were you facing at the time of impact?
O Right O Left O Straight ahead

Estimated damage to the vehicle you were in:
O Mild O Moderate O Major O Total Loss

Type of opposing vehicle involved in accident (Year, Make, Model):
_____

Estimated speed of opposing vehicle involved in accident_____mph
O Stopped O Slowing O Accelerating

Did airbags deploy? O Yes O No If yes, were you struck? O Yes O No

Did you hit your head? O Yes O No If yes, what did you hit your head against?_____

Did other parts of your body strike the interior of the vehicle?
O Yes O No If yes, explain:_____

Did you experience a loss of consciousness ? O Yes O No
If yes, for about how long?_____

Did police show up on scene? O Yes O No
Was there an accident report made? O Yes O No

Please explain in detail how the accident occurred:_____
_____
_____

Were you treated by EMS on the scene? O Yes O No

Did you go to a hospital? O Yes O No
If yes, did you go the same day? O Yes O No
How did you get there? O By Ambulance O Drove Self O By Someone Else
Did you receive imaging studies? O Yes O No If yes, please explain:
_____
Other treatment provided:_____

Have you received treatment elsewhere due to this accident?
O Yes O No If yes, please explain including names of doctors and where you received treatment._____

Review of Symptoms and Past Medical History

Please mark "C" for current symptoms, "P" for past symptoms or leave blank if never.

Ears/Nose
Ear Pain/Ear Infection O C O P
Hay fever O C O P
Ringing in Ears O C O P
TMJ O C O P

Eyes/Vision
Blindness O C O P
Blurred/Double Vision O C O P
Cataracts O C O P
Glaucoma O C O P

Skin
Eczema O C O P
Hives O C O P
Rashes O C O P

Cardiovascular
Chest Pain O C O P
Congestive Heart Failure O C O P
Coronary Artery Disease O C O P
Heart Murmur O C O P
Pacemaker/Defibrillator O C O P
Palpitations O C O P
Swelling of Legs O C O P

Hematologic
Anemia O C O P
Easy Bleeding/Bruising O C O P
Blood Clotting O C O P

Musculoskeletal
Ankle/Foot Pain O C O P
Arthritis O C O P
Balance Problems O C O P
Elbow Pain O C O P
Fibromyalgia O C O P
Hip Pain O C O P
Joint Pain O C O P
Knee Pain O C O P
Low Back Pain O C O P
Muscle Aches O C O P
Muscle Cramping O C O P
Muscle Stiffness(in a.m.) O C O P
Neck Pain O C O P
Pain Between Shoulder O C O P
Pain Wakens You O C O P
Shoulder Pain O C O P
Weakness in Arms/Legs O C O P
Wrist/Hand Pain O C O P

Gastrointestinal
Abnormal Stool O C O P
Constipation O C O P
Crohn's Disease O C O P
Diarrhea O C O P
Reflux/Heartburn O C O P
Nausea/Vomiting O C O P

Throat/Respiratory
Asthma/ Wheezing O C O P
Chronic Cough O C O P
Chest Congestion O C O P
Difficulty Swallowing O C O P
Hoarseness O C O P
Shortness of Breath O C O P
Sore Throat O C O P

Endocrine
Diabetes O C O P
Fatigue/Drowsiness O C O P
Goiter O C O P
Hypo/Hyper Thyroid O C O P
Weight Loss/Gain O C O P

Neurological
Dizziness O C O P
Facial/Limb Weakness O C O P
Fainting O C O P
Headaches O C O P
Migraines O C O P
Numbness/Tingling O C O P
Seizures O C O P
Sleep Disturbance O C O P
Slurred Speech O C O P
Stroke O C O P
Tremor O C O P

Mental/Emotional
Anxiety/Panic O C O P
Clumsy O C O P
Confusion O C O P
Convulsions O C O P
Depression O C O P
Foggy Thinking O C O P
Forgetfulness O C O P
Hyperactive O C O P
Insomnia O C O P
Memory Loss O C O P
Mood Swings/Irritability O C O P
Poor Concentration O C O P
Restless Leg Syndrome O C O P

Urinary
Blood in Urine O C O P
Burning or Pain O C O P
Kidney Stones O C O P
Urgency O C O P

Reproductive
Males Only:
Erectile Dysfunction O C O P
Impotence O C O P
Prostate Enlargement O C O P

Females Only:
Cramps O C O P
Decreased Libido O C O P
Infertility O C O P
Heavy Bleeding O C O P
Irregular Menstruation O C O P
Ovarian Cysts O C O P
Painful Periods O C O P

Current Complaints- Please list in order of severity

First Complaint:_____
Onset: ○ Immediate ○ Within 24 hours ○ After 24 hours
What makes it better?_____
What makes it worse?_____
Quality of pain (Select all that apply)
☐Burning ☐Shooting ☐Dull ☐Ache ☐Sharp ☐Stabbing ☐Numbness
Percentage of time the pain is noted from 0 to 100: _____
Severity of pain on average from 0-10 (0 is no pain, 10 is the highest pain possible) _____

Second Complaint:_____
Onset: ○ Immediate ○ Within 24 hours ○ After 24 hours
What makes it better?_____
What makes it worse?_____
Quality of pain (Select all that apply)
☐Burning ☐Shooting ☐Dull ☐Ache ☐Sharp ☐Stabbing ☐Numbness
Percentage of time the pain is noted from 0 to 100: _____
Severity of pain on average from 0-10 (0 is no pain, 10 is the highest pain possible)_____

Third Complaint:_____
Onset: ○ Immediate ○ Within 24 hours ○ After 24 hours
What makes it better?_____
What makes it worse?_____
Quality of pain (Select all that apply)
☐Burning ☐Shooting ☐Dull ☐Ache ☐Sharp ☐Stabbing ☐Numbness
Percentage of time the pain is noted from 0 to 100: _____
Severity of pain on average from 0-10 (0 is no pain, 10 is the highest pain possible) _____

Fourth Complaint:_____
Onset: ○ Immediate ○ Within 24 hours ○ After 24 hours
What makes it better?_____
What makes it worse?_____
Quality of pain (Select all that apply)
☐Burning ☐Shooting ☐Dull ☐Ache ☐Sharp ☐Stabbing ☐Numbness
Percentage of time the pain is noted from 0 to 100: _____
Severity of pain on average from 0-10 (0 is no pain, 10 is the highest pain possible) _____

Fifth Complaint:_____
Onset: ○ Immediate ○ Within 24 hours ○ After 24 hours
What makes it better?_____
What makes it worse?_____
Quality of pain (Select all that apply)
☐Burning ☐Shooting ☐Dull ☐Ache ☐Sharp ☐Stabbing ☐Numbness
Percentage of time the pain is noted from 0 to 100: _____
Severity of pain on average from 0-10 (0 is no pain, 10 is the highest pain possible) _____

If you have additional complaints, please list:_____

Patient Name:_____**Date:**_____

Rivermead Post Concussion Symptoms Questionnaire

After a head injury or accident, some people experience symptoms that can cause worry or nuisance. We would like to know if you now suffer any of the symptoms given below. Because many of these symptoms occur normally, we would like you to compare yourself now with before the accident. For each symptom listed below, please select the number that most closely represents your answer.

0= Not experienced at all
1= No more of a problem
2= A mild problem
3= A moderate problem
4= A severe problem

Compared with **before** the accident, do you **now** (i.e., over the last 24 hours) suffer from:

	Not Experienced	No more of a problem	Mild problem	Moderate problem	Severe problem
Headaches	o 0	o 1	o 2	o 3	o 4
Feelings of dizziness	o 0	o 1	o 2	o 3	o 4
Nausea and/or vomiting	o 0	o 1	o 2	o 3	o 4
Noise sensitivity (easily upset by loud noise)	o 0	o 1	o 2	o 3	o 4
Light sensitivity (easily upset by bright light)	o 0	o 1	o 2	o 3	o 4
Sleep disturbance	o 0	o 1	o 2	o 3	o 4
Fatigue, tiring more easily	o 0	o 1	o 2	o 3	o 4
Being irritable, easily angered	o 0	o 1	o 2	o 3	o 4
Feeling depressed or tearful	o 0	o 1	o 2	o 3	o 4
Feeling frustrated or impatient	o 0	o 1	o 2	o 3	o 4
Forgetfulness, poor memory	o 0	o 1	o 2	o 3	o 4
Poor concentration	o 0	o 1	o 2	o 3	o 4
Taking longer to think	o 0	o 1	o 2	o 3	o 4
Blurred vision	o 0	o 1	o 2	o 3	o 4
Double Vision	o 0	o 1	o 2	o 3	o 4
Restlessness	o 0	o 1	o 2	o 3	o 4

Are you experiencing any other difficulties? Please specify and rate as above.

1.	o 0	o 1	o 2	o 3	o 4
2.	o 0	o 1	o 2	o 3	o 4

http://www.maa.nsw.gov.au/default.aspx?MenuID=148

Patient Name:_____ **Date:**_____

Loss of Enjoyment of Sports, Hobbies, Travel, Daily Activities and School

Please select all that apply to your EXERCISE & SPORTS activities because of the accident:

- ☐ My exercise was affected by this crash
- ☐ I go to the gym and work out in pain
- ☐ I no longer go to the gym to work out
- ☐ I run but in pain
- ☐ I no longer run
- ☐ I take walks and have pain while walking
- ☐ I no longer take walks
- ☐ I used to make income at sports
- ☐ I am an amateur athlete
- ☐ I am a professional athlete
- ☐ I have gained_____ pounds since the accident
- ☐ I had to quit my _____ team after the accident
- ☐ I had to quit my _____ team after the accident
- ☐ I don't enjoy the sport of _____ anymore
- ☐ I didn't enjoy the sport of _____ for_____weeks
- ☐ I don't enjoy the sport of _____ anymore
- ☐ I didn't enjoy the sport of _____ for_____weeks
- ☐ _____

Please select all that apply to your HOBBY activities because of the accident:

- ☐ My hobbies were affected by the accident
- ☐ Hobby #1_____
- ☐ I can't do hobby #1 anymore
- ☐ I do hobby #1 but in pain
- ☐ I have lost money from not doing hobby #1
- ☐ I didn't do hobby #1 for _____weeks
- ☐ Hobby #2_____
- ☐ I can't do hobby #2 anymore
- ☐ I do hobby #2 but in pain
- ☐ I have lost money from not doing hobby #2
- ☐ I didn't do hobby #2 for _____weeks
- ☐ Hobby #3_____
- ☐ I can't do hobby #3 anymore
- ☐ I do hobby #3 but in pain
- ☐ I have lost money from not doing hobby #3
- ☐ I didn't do hobby #3 for _____weeks
- ☐ Hobby #4_____
- ☐ I can't do hobby #4 anymore
- ☐ I do hobby #4 but in pain
- ☐ I have lost money from not doing hobby #4
- ☐ I didn't do hobby #4 for _____weeks

Please select all that apply to your TRAVEL activities because of the accident:

- ☐ Business travel was affected by the crash
- ☐ Pleasure travel was affected by the crash
- ☐ I hurt driving in my own car
- ☐ I am in too much pain to drive
- ☐ I hurt when a passenger in a car
- ☐ I am in too much pain to sit in a car
- ☐ I have anxiety when I'm in a car
- ☐ I hurt when I'm on an airplane
- ☐ I am in too much pain to travel by plane
- ☐ Travel plan #1 _____
- ☐ I did not go on travel plan #1
- ☐ I went but did not enjoy travel plan #1 as much
- ☐ I went and the accident had no effect on travel plan #1
- ☐ Travel plan #2 _____
- ☐ I did not go on travel plan #2
- ☐ I went but did not enjoy travel plan #2 as much
- ☐ I went and the accident had no effect on travel plan #2
- ☐ I missed time with my family/friends because I can't travel

Please select all that apply to your SCHOOL & EDUCATION activities because of the accident:

- ☐ School was affected by the accident
- ☐ I am a student at _____
- ☐ I am in the _____year/grade
- ☐ I was enrolled (select one) ○ Full time ○ Part-time
- ☐ I am now enrolled (select one) ○ Full time ○ Part-time
- ☐ I had to take fewer classes because of the crash
- ☐ I missed _____ days of school
- ☐ I had to drop out of school because of the crash
- ☐ My grades are lower since the crash
- ☐ I have pain carrying my school books
- ☐ I hurt sitting in class more than _____ minutes
- ☐ My neck hurts when I look down to read
- ☐ I don't learn as quickly as before the crash
- ☐ I don't learn things as well as before the crash
- ☐ I have difficulty concentrating in class
- ☐ It takes much longer to study/do my homework

Please select all the DAILY LIVING activities that cause you pain because of the accident:

- ☐ Dressing
- ☐ Putting on pants
- ☐ Putting on shoes
- ☐ Putting on shirt
- ☐ Tying my shoes
- ☐ Combing my hair
- ☐ Washing my hair
- ☐ Drying my hair
- ☐ Taking a shower
- ☐ Taking a bath
- ☐ Leaning forward
- ☐ Sleeping
- ☐ Laying in bed
- ☐ Going out w/friends
- ☐ Sitting at a restaurant
- ☐ Sitting on my favorite chair
- ☐ Shopping
- ☐ Driving to/from work
- ☐ Sitting in Church
- ☐ Playing with my children
- ☐ Caring for my children
- ☐ Drying w/a towel after showers
- ☐ Sitting in a movie theatre
- ☐ Life has become a chore to do normal things
- ☐ _____
- ☐ Stooping
- ☐ Squatting down
- ☐ Kneeling
- ☐ Brushing my teeth
- ☐ Riding in a car
- ☐ Opening a jar
- ☐ Lifting a pan when cooking
- ☐ Closing the trunk on my car
- ☐ Opening the garage door
- ☐ Using my home computer
- ☐ Climbing stairs
- ☐ Sexual activity
- ☐ Turning my head left or right
- ☐ Holding head up all day
- ☐ Watching TV
- ☐ Sitting and doing nothing
- ☐ Talking on the phone
- ☐ Reading
- ☐ Writing
- ☐ Opening doors
- ☐ Exercise
- ☐ It is depressing to live like this
- ☐ _____
- ☐ _____

Duties Performed Under Duress at Work and Home

Please select all that apply to your WORK activities because of the accident:

- ☐ I go to work but in pain
- ☐ I limit my work activities
- ☐ Bending at work hurts
- ☐ Stooping at work hurts
- ☐ Sitting at work hurts
- ☐ Using the computer at work hurts
- ☐ Pushing at work hurts
- ☐ Kneeling at work hurts
- ☐ I have lost status in my company
- ☐ I have lost job security
- ☐ I didn't get a promotion
- ☐ I don't enjoy work as much as before
- ☐ I doze off at work
- ☐ I take unpaid time off work to go to the doctor
- ☐ I daydream at work more than before
- ☐ I feel tired at work
- ☐ I work in pain because I have bills to pay
- ☐ I can't take time off because I would lose my job
- ☐ I keep working so I don't lose status at my company
- ☐ My business would fail if I took time off
- ☐ I believe in working even though I'm in pain
- ☐ I feel obligated to work even though I'm in pain
- ☐ My business would lose money if I took time off
- ☐ My work is not as good as it was before the accident
- ☐ I got a different job within the same company
- ☐ I got a different job in another company
- ☐ I make less money than before the accident
- ☐ I cannot do the same work/job as before the accident
- ☐ I can't concentrate as well at work
- ☐ I take paid time off to go to the doctor
- ☐ I make mistakes at work I didn't use to
- ☐ I hide my poor work performance from my boss
- ☐ _____
- ☐ _____

Please select all that apply to your HOME/DOMESTIC activities because of the accident:

- ☐ My house is not as clean now
- ☐ My yard is not as neat now
- ☐ My garden is not as productive now
- ☐ I do yardwork but do it in pain
- ☐ I cannot do my normal yardwork
- ☐ I do housework but do it in pain
- ☐ I cannot do my normal housework
- ☐ Doing laundry hurts me
- ☐ I cannot do laundry now
- ☐ Washing dishes hurts me
- ☐ I cannot vacuum now
- ☐ Cooking hurts me
- ☐ I cannot cook now
- ☐ Washing the car hurts me
- ☐ I cannot wash my car
- ☐ I cannot take time off because I care for children
- ☐ I have _____ children ages_____
- ☐ I had to hire a paid housekeeper
- ☐ I asked someone for unpaid housekeeping help
- ☐ I had to hire a paid gardener
- ☐ I asked someone for unpaid yardwork help
- ☐ Mowing the lawn hurts me
- ☐ I cannot mow the lawn
- ☐ Taking out the trash hurts me
- ☐ I cannot take out the trash
- ☐ I do not enjoy my gardening/yardwork like I used to
- ☐ I do not enjoy my housework like I used to
- ☐ Gardening hurts me
- ☐ I cannot do my gardening at all since the accident
- ☐ Others living with me do my share of the housework now
- ☐ Others living with me do my share of the yardwork now
- ☐ Others living with me do my share of the gardening now
- ☐ _____
- ☐ _____

Authorization for Release of Medical Records

I, the undersigned, hereby request and authorize the release of my personal health information to the physicians employed by Acute core medical center.

Purpose: _____ Continuation of Care

Treatment Dates: ____/____/____ to the present

Treating Facility: Acute core medical center

Treating Facility Address: _____
_____

Stat:

Please send all records, including diagnostic studies such as X-rays, CT scans, MRI's, blood work, etc. This patient was seen at your facility for injuries sustained in an automobile accident on or about: ____/____/____

Authorization:

I certify that this request is made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time in writing by sending a letter to the facility Privacy Officer or their designee. I understand my revocation will not be effective to the extent that action has already been taken in reliance on it. This authorization will expire in 365 days. If I have authorized the disclosure of my health information to someone who is not legally required to keep it private, it may be re-disclosed and may no longer be protected.

Other Condition: A copy or facsimile of this form with my signature may be used with the same validity as the original.

Name of Patient:_____ Patient's DOB:_____

Date of Injury:_____Treatment Date:_____

Patient's Signature:_____Date:_____

Auto Accident Insurance/Attorney Information

DATE OF ACCIDENT:_____

WHERE DID THE ACCIDENT HAPPEN?

Kansas: PIP $_____ Missouri: Med Pay $_____ Other State:_____

AUTO ACCIDENT INSURANCE INFORMATION: YOUR INSURANCE INFORMATION
If you have not completed an application of benefits from your auto carrier, you must do so for charges to be covered.

Auto Insurance Carrier:_____

Auto Insurance Phone #:_____

Auto Insurance Mailing Address:_____

Claim Adjuster's Name:_____

Claim #:_____

AUTO ACCIDENT INSURANCE INFORMATION: AT FAULT'S INSURANCE INFORMATION

Auto Insurance Carrier:_____

Auto Insurance Phone #:_____

Auto Insurance Mailing Address:_____

Claim Adjuster's Name:_____

Claim #:_____

GENERAL HEALTH INSURANCE INFORMATION

Health Insurance Carrier:_____

Health Insurance Phone #:_____

Health Insurance Mailing Address:_____

Member ID#:_____ Group #:_____

Insured Person's Name:_____ Insured Person's DOB:_____

ATTORNEY INFORMATION

Attorney Name:_____

Attorney Phone #:_____

Attorney Mailing Address:_____

Contact Person at Attorney's Office:_____

HIPPA Disclosure Acknowledgement

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your right concerning these records. Before we will begin any health care operation, we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your PHI, we encourage you to read the HIPPA NOTICE, this is available upon request at the front desk before signing this consent.

- The patient understands and agrees to Acute core medical center to use their PHI for the purpose of treatment, payment, healthcare, operations and coordination of care.
- The patient has the right to examine and obtain a copy for his or her own health records at any times and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Acute core medical center is not obligated to agree to those restrictions.
- A patient's written consent need only be obtained one time for all subsequent care given to the patient in this office.
- The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
- For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by Acute core medical center to assure that your records are not readily available to those who do not need them.
- Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
- If the patient refuses to sign this consent for purpose of treatment, payment, and healthcare operations, the physicians at Acute core medical center have the right to refuse to give care.

I have read and understand how my Patient Health Information (PHI) will be used and I agree to these policies and procedures.

Signature of Patient or Legal Guardian:_____**Date:**_____

Please list below the names of individuals we may discuss your claim with via phone, leave a voice message with, discuss anything pertaining to your claim, or scheduling appointments for you.

Name:_____ Phone #:_____ Relationship:_____

Name:_____ Phone #:_____ Relationship:_____

Informed Consent for X-rays

I, the undersigned being either the patient named above or the legally authorized representative of the patient named above, do hereby consent to the performance of diagnostic and imaging procedures at Acute core medical center on the terms and conditions more fully set out below. I understand that I have the right to be informed about the diagnostic imaging procedure being used so that I may make a decision whether or not to undergo the procedure.

- Consent to Imaging Procedure: Your attending physician believes it beneficial for you to undergo radiographic imaging to obtain additional information that may aid in diagnosing and treating your medical condition.
- It is important to notify the doctor/technologist if you have a heart pacemaker, brain aneurysm clips, and/or implanted metallic or electronic devices. Please inform the technologist if you are pregnant or think you may be pregnant.
- The benefit of this exam is to assist your physician with making a diagnosis.

By signing below, I hereby certify that I have fully read this consent, had it explained to me, or have had it read to me. I have been given an opportunity to ask questions about my condition, alternative forms of treatment, and procedures to be used, and the risks and hazards involved. I understand its contents and have sufficient information to give this informed consent.

Signature:_____ **Date:**_____

Consent to Evaluate and Adjust a Minor Child

I, _____ being the parent or legal guardian of _____ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Signature:_____ **Date:**_____

Consent for Treatment

I hereby authorize Acute core medical center and/or the providers thereof and whomever he/she may designate as his/her assistant to administer treatment as necessary for care. I understand that the practices of medicine and chiropractic care are not exact sciences and there are not guarantees of the results and that every individual may respond differently to a particular treatment regimen. I understand that there are certain risks associated with an examination or treatment and those risks have been presented and explained to me.

Signature:_____ **Date:**_____

Important Note to Patient:

Please note, we will be developing a treatment plan in order to facilitate a complete recovery from your injuries. But in order to do so, your assistance is needed. We ask that you make necessary arrangements to make appointments according to your treatment plan. If there is a compliance issue, we will need to make the attorney aware of this situation.

I have read and understand the above statement.

Signature:_____ **Date:**_____

Assignment and Lien Agreement

Preamble and Purpose: If you are presented with this Agreement, you have indicated to Core medical center ("CMC") located at **Core Medical Center 1131 w main st.Blue Spring, MO, 6415** that you have been involved in an injury causing event that You believe some other person or party is legally responsible for causing such injuries. The purpose of this Assignment & Lien Agreement is to provide You with immediate and ongoing healthcare treatment as is reasonably necessary to treat your injuries while providing Youwith sufficient time to obtain a monetary settlement or legal Judgment as a result of some other person or party causing Your injuries. In executing this Agreement, You are promising to CMC that You will directly or indirectly pay the outstanding balance of any charges for any healthcare treatment or services provided by CMC to You promptly after receiving the funds acquiredfrom any settlement or judgment You may acquire.

Accordingly, I,_____ (Name of Patient), agree to the following terms:

1. I agree to assign CMC the monetary proceeds from any recovery I receive as a result of my claim that some other person or party is responsible for causing my injuries and in an amount necessary to satisfy any outstanding unpaid balance I may have for past healthcare services and/or treatment provided by and through CMC.
2. I authorize CMC to seek full or partial payment for healthcare services provided by CMC from any *auto insurance carrier* who may be responsible for providing me with insurance benefits through Personal Injury Protection, Medical Payments coverage or some other medical insurance benefit derived from an *auto insurance carrier*. I further agree to cooperate with CMC in acquiring information related to *auto insurance benefits*, which may pay in full or in part for healthcare services and treatment provided by CMC.
3. In the event I have retained or later retain an attorney to represent my legal interests for the purpose of acquiring compensation for injuries caused by a person or party responsible for my injuries, I hereby authorize and direct my attorney to withhold monetary funds from any recovery I may acquire in settlement or through Judgment from any third party I claim is responsible for compensating me for an injury caused by some other person or party and direct my attorney to promptly provide these monetary funds to CMC for the express purpose of satisfying any outstanding and unpaid balance for healthcare treatment and/or services provided through CMC. In the event of recovery, I further authorize and direct any attorney I have retained to provide CMC with reasonable requests for information related tothe amount of recovery I have acquired through a settlement or Judgment.
4. I authorize CMC to provide a copy of this Assignment & Lien Agreement to any attorney I may retain and any third party or insurance carrier who may be legally responsible for compensating me for treatment and services provided to me through CMC as a result of injuries caused by another person or party.
5. I understand and agree in executing this Agreement that CMC does not accept healthcare insurance benefits and CMC will be taking no action directly or indirectly to acquire payment for healthcare treatment and/or services provided by CMC from any healthcare insurance provider who may provide benefits to me.
6. I understand and agree that by executing this Agreement, my obligations for payment to CMC are not contingent upon my ability to make a successful monetary recovery from some other third party for injuries I believe to have beencaused by some other person or party and further understand and agree that I shall be responsible to CMC for any outstanding unpaid balance that may exist for past healthcare treatment and services provided by CMC in the event I am unable to acquire a financial recovery that satisfies all or a portion of my unpaid balance after attempting to hold a third party legally responsible for injuries caused upon me.
7. I understand and agree that in an event I fail to comply with the terms and obligations set forth in this Agreement, CMC shall be entitled to seek legal recourse in a court of competent jurisdiction where it may seek recovery for any outstanding unpaid balance for healthcare treatment and services provided to me, interest at a rate of (18%) per annum accrued from the date of my breach of this Agreement and CMC shall be additionally entitled to seek any and all reasonable costs necessary to legally enforce this Agreement, including but not limited to reasonable attorney's fees.

In affixing my signature below, I am affirming that I have had the opportunity to read this Agreement, had the opportunity to ask questions as to the meaning of its terms to my satisfaction and agree to all of the terms set forth.

Total Due:_____

Patient Name:_____ Patient Signature:_____

Parent/Guardian Signature:_____ Date:_____

Doctor's Name:_____ Doctor's Signature:_____