ADVANCED HEALTH & PAIN CENTER

ADVANCED HEALTH & PAIN CENTER
301 NORTH 200 EAST - SUITE 1D, ST. GEORGE, UT 84770
TELEPHONE: (435) 652-8380 - FAX (435) 674-5919

WELCOME

Please present your Drivers License and Insurance Cards (if applicable) to copy.

Thank you for choosing our practice for your chiropractic needs. Please complete this form in ink.
If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

PATIENT INFORMATION

Please PRINT

Last Name: _____ SS No.: _____

First Name: _____ MI: _____

Address: _____ Gender: _____ Marital Status: _____

_____ □ Male □ Minor □ Widowed

City: _____ □ Female □ Married □ Single

State: _____ Zip: _____ □ Divorced □ Separated

Home Phone: _____ Ext'n: _____

Cell Phone: _____ Do you prefer to receive calls at □ Home □ Cell □ Either

Birth Date: _____ Age: _____ Email Address _____

Your Employer: _____ Occupation: _____

Employer's Address: _____ City: _____ State: _____ Zip: _____

Spouse's or Parent's name: _____ Work Phone: _____

Person to contact in case of an emergency: _____ Phone: _____

RESPONSIBLE PARTY

Please PRINT

Name of person responsible for this account? _____

Relationship to patient: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Name of Employer: _____ Work Phone: _____

INSURANCE INFORMATION

Please PRINT

Name of insured: _____ Relationship to Patient: _____

Birth Date: _____ SS No if insured: _____

Insurance Co.: _____ Group No.: _____

Address: _____ City: _____ State: _____ Zip: _____

DO YOU HAVE ADDITIONAL INSURANCE: □Yes □ No IF SO, PLEASE COMPLETE THE FOLLOWING:

Name of insured: _____ SS No of insured: _____

Insurance Co.: _____ Group No.: _____

Address: _____ City: _____ State: _____ Zip: _____

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AUTOMOBILE ACCIDENT ONLY

AUTO INSURANCE YOUR VEHICLE

Insurance Co.: _____

Telephone No.: _____

Agents Name: _____

Owner of Vehicle: _____

Year and Make: _____

Were You? ☐ Driver ☐ Passenger

Policy No.: _____

Claim No.: _____

Estimated amount of damage to your vehicle $ _____

Citation issued to: ☐ You ☐ Other driver

AUTO INSURANCE OTHER VEHICLE

_____

_____

_____

_____

_____

Date of Accident: _____

Date you reported accident to Agent: _____

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HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present and future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in ordered to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients in our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required by Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures: Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use of disclosure indicated in the authorization.

Your Rights:

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to see another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternate means or at an alternate location, You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints:

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our private contact of your complaint. **We will not retaliate against you for filling a complaint**.

This notice was published and becomes effective on/or before **April 14, 2003**.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and private practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person of by phone at the Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Policies:

Print Name: _____

Signature: _____

Date: _____

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MOTOR VEHICLE ACCIDENT

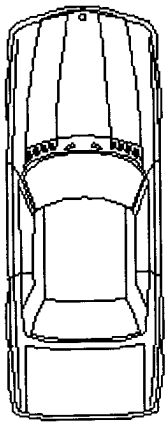
Date of Injury: Today's Date:

Name: Birth Date: Age: ☐ Male ☐ Female

Describe how the injury happened:

AUTOMOBILE ACCIDENT: Damage $

FRONT



Were you the: ☐ Driver ☐ Passenger: ☐ Front ☐ Rear

Seat Belt: ☐ Yes ☐ No ☐ Lap ☐ Shoulder

Vehicle was: ☐ Moving ☐ At a stop

Vehicle Struck: ☐ Head-on ☐ Rear-ended ☐ Passenger side ☐ Driver side

During Impact: ☐ Brace w/arms ☐ Brace w/legs ☐ Steering wheel ☐ Dash ☐ Seat ☐ Floor ☐ Brakes ☐ Don't remember

Head: ☐ Straight Turned: ☐ Right ☐ Left ☐ Strike headrest

REAR

O = Where patient sat

X = Where impact occurred

Strike any part of body: (Against what)

After collision: ☐ Lost consciousness? Minutes:

Did you feel? ☐ Nervous ☐ Stunned ☐ Scared ☐ Dizzy ☐ Disoriented ☐ Lightheaded ☐ Confused

Immediate symptoms:

Subsequent symptoms:

Evaluated by Paramedics? Taken to Hospital? Via ambulance?

Any emergency treatment?

Initial treatment: When: Where:

Doctor's Name & Specialty:

Type of treatment:

Subsequent treatment: (including all Doctors and testing)

1

Subsequent treatment - continued: (including all Doctors and testing)

2

3

4

Was anyone in the vehicle with you?

CURRENT COMPLAINTS

1

2

3

4

PAST MEDICAL HISTORY

Prior injuries: Motor Vehicle:

Work:

Sports:

Other:

Major surgeries:

Hospitalizations:

Major illnesses: ☐ Hypertension ☐ Heart Disease ☐ Diabetes ☐ Ulcers ☐ Cancer

☐ Lung Conditions ☐ Kidney Problems ☐ Hernia ☐ Tuberculosis

☐ Other:

Family history of any of the above conditions? (Who/Which)

Is there any chance that you are pregnant at this time? ☐ Yes ☐ No

Allergies:

Current Medications:

Events of Accident in Patients Own Words

Events of Accident in Patients Own Words (Continued)

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NAME: _____ **DATE:** _____

1. What is the **MAIN** problem/symptom you are having?

_____

- Place a mark through the line to rate your pain/symptom today.

|_____|
No pain *Pain as bad as it could be*

- Circle the **ONE** that **BEST** describes how **OFTEN** you have your pain.
  1) All the time
  2) Most of the time
  3) A good bit of the time
  4) Some of the time
  5) A little of the time
  6) Hardy any of the time
  7) None of the time

Hx for HA:
Location: R L B Occipital / Frontal / Temporal
Freq.: C 1 2 3 4 5 6 7 / W / M
Intensity: Forgot / Not Forgot / Stops Act. / Cries-pain
Lasts: _____/ M / H / ALL D

- What have you noticed that makes this conditon **WORSE**?

_____

_____

- What have you noticed that makes this conditon **BETTER**?

_____

_____

- Please check the word(s) that best describes this symptom.

☐ sharp ☐ shooting ☐ stabbing ☐ dull
☐ achy ☐ numb ☐ tingly ☐ burning

---

2. What is the **NEXT** most bothersome problem/symptom you are having?

_____

- Place a mark through the line to rate your pain/symptom today.

|_____|
No pain *Pain as bad as it could be*

- Circle the **ONE** that **BEST** describes how **OFTEN** you have your pain.
  1) All the time
  2) Most of the time
  3) A good bit of the time
  4) Some of the time
  5) A little of the time
  6) Hardy any of the time
  7) None of the time

- What have you noticed that makes this conditon **WORSE**?

_____

_____

- What have you noticed that makes this conditon **BETTER**?

_____

_____

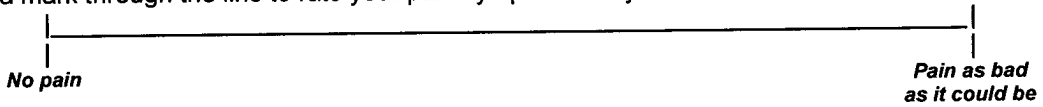
- Please check the word(s) that best describes this symptom.

☐ sharp ☐ shooting ☐ stabbing ☐ dull
☐ achy ☐ numb ☐ tingly ☐ burning

3. What is the **NEXT** most bothersome problem/symptom you are having?

_____

- Place a mark through the line to rate your pain/symptom today.



- Circle the **ONE** that **BEST** describes how **OFTEN** you have your pain.
  1) All the time
  2) Most of the time
  3) A good bit of the time
  4) Some of the time
  5) A little of the time
  6) Hardy any of the time
  7) None of the time

- What have you noticed that makes this conditon **WORSE**?

_____

_____

- What have you noticed that makes this conditon **BETTER**?

_____

_____

- Please check the word(s) that best describes this symptom.

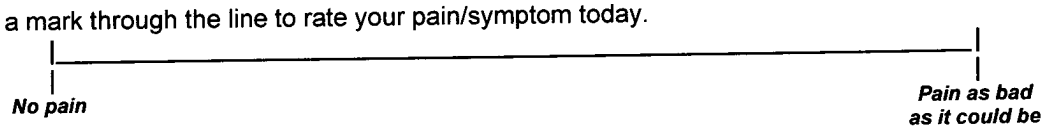
☐ sharp ☐ shooting ☐ stabbing ☐ dull
☐ achy ☐ numb ☐ tingly ☐ burning

---

4. What is the **NEXT** most bothersome problem/symptom you are having?

_____

- Place a mark through the line to rate your pain/symptom today.



- Circle the **ONE** that **BEST** describes how **OFTEN** you have your pain.
  1) All the time
  2) Most of the time
  3) A good bit of the time
  4) Some of the time
  5) A little of the time
  6) Hardy any of the time
  7) None of the time

- What have you noticed that makes this conditon **WORSE**?

_____

_____

- What have you noticed that makes this conditon **BETTER**?

_____

_____

- Please check the word(s) that best describes this symptom.

☐ sharp ☐ shooting ☐ stabbing ☐ dull
☐ achy ☐ numb ☐ tingly ☐ burning

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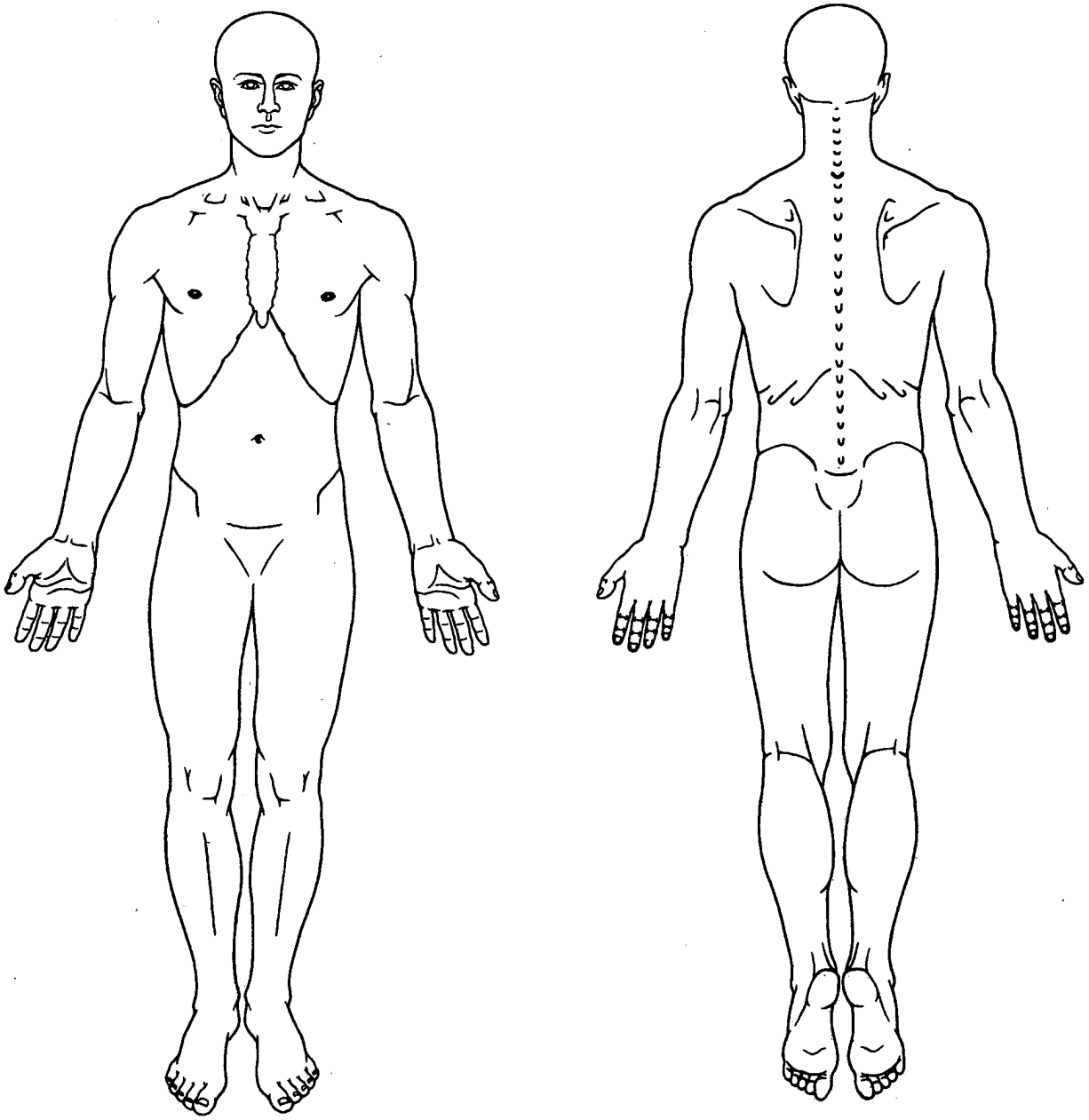
MARK AREAS ON THE BODY WHERE YOU FEEL THE DESCRIBED SENSATIONS

NUMBNESS	ACHES	PINS & NEEDLES	BURNING	STABBING	OTHER
====	AAAA	OOOO	XXXX	////	* * * *
====	AAAA	OOOO	XXXX	////	* * * *
====	AAAA	OOOO	XXXX	////	* * * *
====	AAAA	OOOO	XXXX	////	* * * *



INFORMED CONSENT FOR CHIROPRACTIC TREATMENT AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures,
including various modes of physiotherapy and diagnostic x-ray, on me (or on the patient named below for whom
I am legally responsible) by the doctor or intern affiliated with Advanced Health & Pain Center.

I understand that, as in the practice of medicine, in the practice of chiropractic care there are some risks to treatment, including but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications. I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts then known, is in my best interests.

I have read, or have had read to me, the above consent. By signing below I agree to the above, and allow the doctor or intern affiliated with Advanced Health & Pain Center to perform such. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Signature Date

CONSENT TO TREATMENT OF MINOR CHILD

I hereby authorize Advanced Health & Pain Center, the Doctors and whoever is designated as assistant, to administer treatment as is deemed necessary to my son/daughter,

Patient Name

Legal Guardian Signature Date

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ACKNOWLEDGMENT OF LIABILIY AND ASSIGNMENT OF BENEFITS

The undersigned patient and/or responsible party, hereby acknowledges personal responsibility and liability for all medical services which are provided by Advanced Health & Pain Center, and all Doctors associated with it. This personal obligation is not affected by any obligation of insurance companies to pay health care costs. If an insurance company pays, the payments shall be credited to your account. If no insurance payment is received, you are completely responsible to pay for all medical treatments. In addition to continuing personal responsibility, and in consideration of treatment rendered or to be rendered, the undersigned hereby assigns the physician or facility named above the following rights, power and authority:

RELEASED INFORMATION: You are authorized to release and to permit the examination or copying of any of my medical records, x-rays, laboratory reports and the results of all tests of any type or character to such person(s) as the physician and/or facility deems appropriate.

ASSIGNMENT OF RIGHTS: You are assigned the exclusive, irrevocable right to any cause of action that exists in my favor against any insurance company or other person or entity to the extent of your bill for total services, including the exclusive, irrevocable right to receive payment for such services, make demand in my name for payments, and prosecute and receive penalties, interest, court costs, or other legally compensable amounts owed by an insurance company or other person or entity. I as the patient and/or responsible party, further agree to cooperate, provide information as needed and appear as needed, wherever to assist in the prosecution of such claims for benefits upon request. The physician and/or facility is also assigned the exclusive, irrevocable right to request and receive from any insurance company or health care plan any information or supporting documentation concerning or touching upon the handling, calculation, processing, or payment of any claim.

DEMAND FOR PAYMENT: To any insurance company providing benefits of any kind to me/us for treatment rendered by the physician/facility named above, you are hereby tendered demand to pay in full the bill for services rendered by the physician/facility named above, following your receipt of such bill for services to the extent such bills are payable under the terms of my/our policy for benefits, less any amount which I/we owe personally which are not payable under the terms of you policy.

THIRD PARTY LIABILITY: If patient(s) treatments for injuries are the result of the negligence of any third party, then patient(s) grant a secured interest (lien) against any recovery from such third part(s) to the extent of the bills for treatment in favor of the physician/facility named above.

STATUTE OF LIMITATIONS: Patient(s) waive the right to claim any Statute of Limitations regarding claims for services rendered or to be rendered by the physician/facility named above.

TERMS AND ATTORNEY FEES: Net 30 days from date of invoice unless otherwise indicated. A finance charge of 1.5% per month (annual percentage rate of 18%) of the unpaid balance may be added monthly, both pre-judgment and post-judgment. Should collection become necessary, the patient(s) agrees to pay and additional 50% collection fee and all legal fees of collection, with or without suit, including attorney fees and court costs for services rendered by the physician/facility named above.

RETURNED CHECK DISCLAIMER: I/We agree to pay $25.00 returned check fee, attorney's fees of $150, all court, filing fees and charges or commissions of fifty percent that may be assessed to us by any collection agency retained to pursue this matter. I/We further agree to pay interest at the rate of one and one half percent per month (eighteen percent per year).

LIMITED POWER OF ATTORNEY: I hereby grant to the physician/facility named above power of attorney to endorse my name upon any checks, drafts, or other negotiable instrument representing payment from any insurance company, representing payment for treatment and health care rendered by physician/facility. Additionally I grant the physician/facility the power of attorney to complete and sign any paperwork required to facilitate payment for care relative to injuries from a motor vehicle collision, i.e.; P.I.P. (Personal Injury Protection) application or other paperwork which may be required. I agree that any insurance payment representing an amount in excess of the charges for treatment rendered will be credited to my/our account or forwarded to my/our address upon request in writing to the physician/facility named above. In the event that any provision of this Agreement is determined to be invalid or unenforceable, all other provisions of this Agreement shall remain enforceable.

A PHOTOCOPY OF THIS INSTRUMENT SHALL SERVE AS ORIGINAL.

Signatures of Patients and Responsible party:

Signature _____ Date _____ SS# _____

Print Name _____ Address _____

ADVANCED HEALTH
&
PAIN CENTER

Name_____

ADVANCED HEALTH & PAIN CENTER
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PERSONAL INJURY
FINANCIAL INFORMATION

Thank you for choosing Advanced Health & pain Center to provide your care following your motor vehicle collision. We promise to provide you with the finest care available. The following is information that will be helpful to you in understanding how our office interacts with your automobile insurance as well as our billing procedures.

Utah-A No Fault State
Even though you may not have been the at-fault party in your collision, Utah is considered a No-Fault State. That means that you must file a claim with your automobile insurance company and receive a claim number. Your insurance company will pay your medical bills up to your individual personal injury protection limit (PIP) and then seek reimbursement from the at-fault insurance company. The minimum PIP limit is $3,000.00. However, there are higher limits. You will want to consult your individual policy to find out what your PIP limit is.

Personal Injury Protection (PIP) Application
Shortly after you have filed a claim with your automobile insurance, you will receive a PIP application from your insurance company. Please complete that paperwork promptly and return it to your insurance company. That signed application allows your insurance company to pay your claims. Without that application, your insurance company will deny your claims. If you have any questions regarding that paperwork, we will be glad to assist you.

PI Fee Schedule
Our fees for personally injury claims differ from regular health insurance fees. The fees are established by the Insurance commission of the State of Utah. They are different than regular health insurance fees.

Attorney
If your case requires an attorney, we can provide you with the names of attorneys that we have had positive experiences with. Please contact the billing department with any questions.

Lien
You will be asked to sign a patient lien as part of your new patient paperwork. This lien protects us and assures that we will be paid from your settlement should your case require the assistance of an attorney. The lien is sent to you attorney for his signature and a copy is placed in your file here as well as with the attorney.

Date_____Initials_____

PERSONAL INJURY FINANCIAL INFORMATION

If you have not already filed a claim with your automobile insurance company and received a claim number, you are encouraged to do so immediately. A claim number is an identification number for your insurance company to reference in order to pay your claims.

I have read and understand the above information.. I understand that after my automobile insurance has paid according to their limits and after any insurance company settlements, I am ultimately responsible for payment of any unpaid balance for my chiropractic care resulting from this motor vehicle collision.

_____ _____

Patient Name Date

_____ _____

(Minor) Parent/Guardian Date

_____ _____

Witness Date

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Patient Name:_____

MEDICAL REPORT and DOCTOR'S LIEN

I do hereby authorize Advanced Health & Pain Center to furnish you, my attorney, and or insurance company, with a full report of examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was recently involved.

I hereby authorize and direct you, my attorney, and or insurance company, to pay directly to said clinic such sums as may be due and owing for medical services rendered me by reason of this accident to withhold such sums from any settlement, judgment or verdict as said clinic against any and all and notify you of a portion of proceeds of my settlement, judgment or verdict which may be paid to you, my attorney, or myself, as the result of the injuries for which I have been treated of injuries in connection wherewith.

I agree never to rescind this document and that rescission will not be honored by my attorney, and or insurance company. I hereby instruct that in the event another attorney is substituted in this matter, the new attorney honor this lien as inherent to the settlement and enforceable upon the case as if it were executed by him. I fully understand that I am directly and fully responsible to said clinic for all medical bills submitted for service rendered me and that this is made solely for said clinic's additional protection and in consideration of awaiting payment. And I further understand that such payment in not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

Please acknowledge this letter by signing below and returning to Advanced Health & Pain Center, I have been advised that if my attorney does not wish to cooperate in protecting the clinic's interest, the clinic will not await payment but will require me to make payments on current basis.

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 for any settlement, judgment, or verdict, as may be necessary to adequately protect said clinic above-named.

Dated _____ Attorney's Signature _____

Dated_____ Authorized Agent _____
Please sign all three copies, date and return two copies to the address above. Also keep one copy for your records.

Strehlow Radiology Consultation Requisition

Patient Information & Past Medical History

☐ MVA ☐ Acute Injury ☐ Insidious Onset ☐ Other

☐ Malignancies ☐ Surgeries ☐ Congenital Anomalies

Patient Name (Please print clearly) ☐ Female ☐ Male

Patient's Home Address

City, State, Zip Code

Social Security Number

Home Phone Number

Patient Date of Birth

Date of Injury

Billing Information

Referring Physician

☐ Attorney ☐ Insurance ☐ Physician ☐ Patient

See attached paperwork ☐ Past Medical History ☐ Billing

Name of Attorney / Insurance Carrier

Address of Attorney / Insurance Carrier

City, State, Zip Code

Insurance Policy Number

Accident Claim Number

Name of Adjuster

Adjuster's Phone Number

AN INFORMED CONSENT: To insure the highest quality of interpretation, the services of Strehlow Radiology Consulting, LLC, are being utilized to obtain a secondary opinion on my x-rays or other advanced imaging study. I understand that there is a separate fee for this service and that this fee may be billed directly by SRC In accordance with the Medicare Act, this is to advise you that this is a non-covered service

RELEASE OF INFORMATION: I do hereby authorize the above doctor / consultant to obtain from and to furnish to my physician, attorney, and or insurance carrier a full report of my case history, examination, diagnosis, and prognosis in regard to my accident and / or illness

DOCTORS LIEN: I do hereby give a lien to the above doctor / consultant on any settlement, claim, judgment, or verdict as a result of the accident and or illness, and authorize and direct you, my attorney / insurance carrier to pay directly to the said doctor / consultant (Strehlow Radiology Consulting, LLC @ 141 W. Brigham Rd., Suite B - St. George, UT 84790) such sums as may be due and owing him for the services rendered me, and to withhold such sums from the settlement, claim, judgment, verdict as may be necessary to pay said doctor / radiology consultant **I UNDERSTAND THAT I AM DIRECTLY RESPONSIBLE TO SAID DOCTOR / CONSULTANT FOR ALL CHIROPRACTIC - RADIOLOGY BILLS SUBMITTED BY HIM FOR SERVICES RENDERED ME**, and that this agreement is made solely for said doctor / consultant additional protection and in consideration of his awaiting payment. I further understand that such payment is not contingent on any settlement, claim, judgment, or verdict by which I may eventually recover. I further agree never to rescind this agreement and instruct my attorney that any attempted rescission on my part shall be null and void. I also agree that this agreement shall be binding upon any substitute counsel retained by me and that I will promptly notify the said doctor / Strehlow Radiology Consulting of any substitution of counsel or changes in my home address.

SIGNATURES & COPIES: I do hereby grant power of attorney to the said doctor / consultant for the discrete sole purposes of signing two-party checks received in the Strehlow Radiology Consulting, LLC name and or when dual signatures are required for payment on a check from an insurance company, and with the signing privilege related to insurance benefit applications in lieu of habeas corpus and forms related to the stated injury for which services have been rendered to facilitate the completion of insurance for processing the claim. I do hereby state and agree that a photocopy or facsimile of this document will be as valid and binding on all parties involved as the original document

Patient / Guardian Signature Date

The undersigned, being the attorney of record or an authorized representative for the above patient does hereby acknowledge this lien and does agree to honor the same to protect adequately said above named doctor / Strehlow Radiology Consulting, LLC

Attorney Signature Date

STREHLOW RADIOLOGY CONSULTING

1-800-330-0772 Fax: (435) 674-2588

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