ProRehab
Integrated Healthcare Specialists LLC

***Independent Providers***

Kyle Tetz, DC

***Services***

Chiropractic Care

Physical Therapy

Acupuncture

Massage Therapy

Spinal Rehab

Sports Injury Rehab

Auto Injury Rehab

Corrective Exercises

Nutritional Counseling

***Location***

410 S. Melrose Dr

Suite 200

Vista, CA 92081

***Contact***

P: 760.630.8060

ProRehabWellness.com

# Preparing for Your First Appointment

Documents to Bring:

- ☐ Chiropractic Intake Forms
- ☐ Driver's license or ID
- ☐ Accident Photos – can be emailed to: Info@prorehabwellness.com
- ☐ Accident Report – if available
- ☐ Estimates of damage – if available
- ☐ X-Rays / MRI / Medical Records
- ☐ Med-Pay verification
- ○ Auto Insurance Declaration Statement
- ○ Auto Adjuster's Phone # and Claim #
- ☐ Attorney Information – if applicable
- ☐ Third Party Insurance Info.

About your Appointment:

- Allow up to 60 - 90 minutes for your first appointment. Please arrive 45-60 minutes early if you have not already completed your initial paperwork.
- Comfortable athletic clothing is highly recommended. This allows the doctor to properly evaluate injured areas.
- Failure to bring in above documents may delay the initiation of treatment.

Thank you for trusting ProRehab Integrated Healthcare Specialists with your health.

We look forward to meeting you soon!

ProRehab
Integrated Healthcare Specialists LLC

INSTRUCTIONS: Please use sections below to help you complete your forms.

[ PAGE: 1 ]

### Medical History Section

- ☐ Please include symptoms you are currently experiencing since the accident + before the accident.

[ PAGE: 2 ]

**It is HIGHLY important that you list all symptoms you are experiencing since your accident. You must separate symptoms in order of highest to lowest.**

- ☐ Please write down symptoms on separate lines. Worst, Second Worst, Third Worst. (Section 5 for additional symptoms)

Remember use the sections 1, 2, & 3 in the order of most pain to least pain. Always provide a pain score 1-10, *10 means you are in the hospital*. Please use the pain scale attached to help you score your pains. Include how often you experience each symptom.

IF you have more than 3 complaints/ symptoms please use section 5.
To include 4th, 5th, 6th complaints/ symptoms please use same format.

- ☐ Section 4. Please use the keys to mark where you are having pain on the picture provided. Ex. "XXX" for pain, "///" for stiffness, "OOO" for numbness, "SSS" for stabbing.

### ADL [activities of daily living]

- ☐ Mark ONE answer for each line, ONLY if it applies. If it does not apply to you, you can skip that line.
- ☐ Sign this form when finished.

### Upper Extremity

- ☐ Complete this form, ONLY if you are having pain in areas: arms, hands, wrists...

### Lower Extremity

- ☐ Complete this form, ONLY if you are having pain in the legs, knees, or feet.

### Release form for medical records

- ☐ Only a signature is required.
- ☐ Leave blank.

### Personal Injury Fee Schedule

- ☐ Please provide your insurance declarations page to help you determine if you have medical coverage under your auto insurance policy.
- ☐ Chiropractic treatments will be under a lien; however, supplies may include a small co-pay if no medical coverage is available to cover expenses.

| | |
|---|---|
| 0 | No Pain |
| 1 | Minimal Pain (Annoyance) |
| 2 | Constant Minimal to Intermittent Slight Pain |
| 3 | Constant Slight Pain (Some Handicap) |
| 4 | Constant Slight to Intermittent Moderate Pain |
| 5 | Constant Slight to Frequent Moderate Pain |
| 6 | Intermittent Moderate Pain (Marked Handicap) |
| 7 | Frequent Moderate Pain |
| 8 | Constant Moderate Pain |
| 9 | Constant Moderate to Intermittent Severe Pain |
| 10 | Constant Severe Pain (Incapacitated) |

# PATIENT INFORMATION & MEDICAL HISTORY

First Name _____ Last Name _____ Middle Initial ____ Sex (M / F)

Address _____
(number) (street) (city) (state) (zip code)

Social Security# _____-_____-_____ Birth Date ____ / ____ / _____ Age _____

Phone # (_____) _____ - _____ Cell # (_____) _____ - _____ Email _____

Married ( ) Single ( ) Other ( ) _____ Spouse's Name _____

Occupation _____ Employer _____ Work Address _____

IN CASE OF AN EMERGENCY, CONTACT _____
Name Relationship Phone #

*Have you ever had chiropractic care before?* (YES / NO) If yes, when was your last treatment? _____

*Have you ever had a professional massage before?* (YES / NO) If yes, when was your last massage? _____

*What are your health goals?* (Check one of the following)

( ) Reduce symptoms only ( ) Reduce symptoms and show me how to prevent flair-ups ( ) Reduce symptoms, prevent flair-ups and maintenance care

Do you have any type of health insurance? (YES / NO) Primary Insurance _____ Secondary Insurance _____

Is this injury work related? (YES / NO) Is this injury due to a motor vehicle accident? (YES / NO)

*** IF YOU ANSWERED YES TO EITHER OF THE TWO PREVIOUS QUESTIONS, PLEASE NOTIFY THE FRONT DESK ***

## PAST YEAR MEDICAL HISTORY

*Check any of the following symptoms you are **currently experiencing or have experienced within the past 12 months.***

**Musculoskeletal**
__Low Back Pain
__Pain Between Shoulders
__Neck Pain
__Headaches
__Arm Pain/Numb/Tingling
__Leg Pain/Numb/Tingling
__Joint Pain/Stiffness
__Walking Problems
__Difficulty Chewing
__Weakness

**EENT**
__Vision Problems
__Dental Problems
__Sore Throat
__Ear Pain/Ringing
__Hearing Difficulty

**General**
__Allergies
__Loss of Sleep
__Fever/Night Sweats
__Eczema (skin rash)
__Weight Loss/Gain

**Genitourinary**
__Bladder Trouble
__Painful Urination
__ Excessive Urination
__Discolored Urine

**Male Specific**
__Difficulty Urinating
__Impotence
__Sterility

**C-V-R**
__Chest Pain
__Short of Breath
__Blood Pressure
__Heart Problems
__Wheezing
__Lung Problems
__Varicose Veins
__Arm/Leg Swelling
__Asthma
__High Cholesterol
__Bruise Easily

**Female Specific**
__Menstrual Irregularity
__Menstrual Cramping
__Sterility
__Breast Pain

*****ARE YOU PREGNANT? (YES / NO)*****

**Nervous**
__Numbness
__Paralysis
__Dizziness
__Forgetfulness
__Confusion
__Depression
__Fainting
__Convulsions
__ADHD/Hyperactivity
__Anxious
__Tremor/Shaking

**Gastrointestinal**
__Gas/Bloating
__Heartburn
__Poor Appetite
__Excessive Appetite
__Excessive Thirst
__Decreased Appetite
__Colitis
__Vomiting
__Diarrhea
__Constipation
__Black/Bloody Stool
__Hemorrhoids
__Liver Problems
__Abdominal Pain
__Frequent Nausea

Name of your family physician _____ Last appointment with your physician _____ Phone # _____

Do you give us permission to send your medical doctor an updated report on your health status? (YES / NO)

Have you been hospitalized in the past? (YES / NO) If yes when and why? _____

Please list any surgeries you have had and when.

_____

Please list any medications you are taking.

_____

**PATIENT SIGNATURE** _____ **DATE** _____

## SUBJECTIVE COMPLAINTS / INTENSITY / FREQUENCY

Name _____ **(Complete sections 1-6)** Date _____

1. What is your **WORST** complaint or symptom? _____

**When** and **How** did this condition begin? _____

Rate your pain/discomfort on the scale. (circle) (no pain) = **0 1 2 3 4 5 6 7 8 9 10** = (severe pain)

What % of the day or **Frequency** of this symptom experienced? (circle below)

0-5 6-10 11-15 16-20 21-25 26-30 31-35 36-40 41-45 46-50 51-55 56-60 61-65 66-70 71-75 76-80 81-85 86-90 91-95 96-100

Is this condition and symptom changing? (circle) **Improving** **Not Changing** **Worsening**

2. What is your **SECOND WORST** complaint or symptom? _____

**When** and **How** did this condition begin? _____

Rate your pain/discomfort on the scale. (circle) (no pain) = **0 1 2 3 4 5 6 7 8 9 10** = (severe pain)

What % of the day or **Frequency** of this symptom experienced? (circle below)

0-5 6-10 11-15 16-20 21-25 26-30 31-35 36-40 41-45 46-50 51-55 56-60 61-65 66-70 71-75 76-80 81-85 86-90 91-95 96-100

Is this condition and symptom changing? (circle) **Improving** **Not Changing** **Worsening**

3. What is your **THIRD WORST** complaint or symptom? _____

**When** and **How** did this condition begin? _____

Rate your pain/discomfort on the scale. (circle) (no pain) = **0 1 2 3 4 5 6 7 8 9 10** = (severe pain)

What % of the day or **Frequency** of this symptom experienced? (circle below)

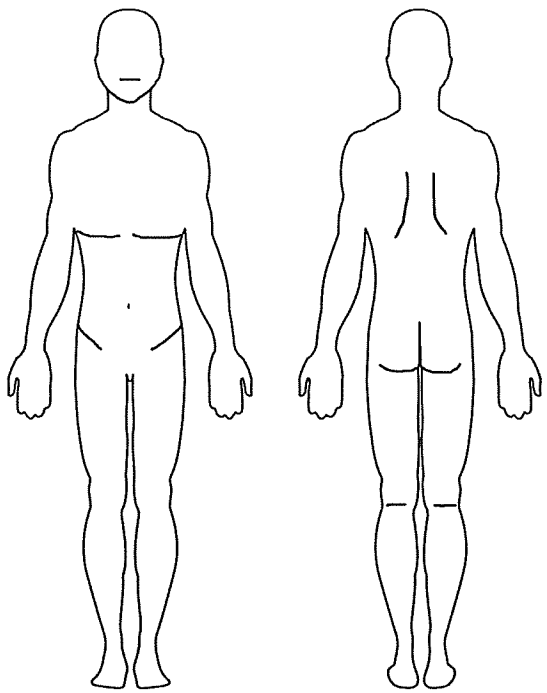
0-5 6-10 11-15 16-20 21-25 26-30 31-35 36-40 41-45 46-50 51-55 56-60 61-65 66-70 71-75 76-80 81-85 86-90 91-95 96-100

Is this condition and symptom changing? (circle) **Improving** **Not Changing** **Worsening**

4. Please indicate on the diagram to the right where you experience your symptoms using the key below.

**KEY: Pain XXX Numbness OOO Tingling √ √ √**

**Stiffness / / / Burning + + + Stabbing SSS**



5. Include additional symptoms using the same format as above. For each symptom, please rate your pain/ discomfort 1-10, % frequency, & if improving, not changing or worsening:

4th Complaint/ Symptom: _____

_____

5th Complaint/ Symptom: _____

_____

6th Complaint/ Symptom: _____

_____

6. **Patient Signature:** _____

*Kyle Tetz Chiropractic Inc.— 410 S. Melrose Drive, Ste 200, Vista, CA 92081—Ph: 760.630.8060*

# NEW PATIENT CURRENT COMPLAINTS & PAST HISTORY

Name _____ **(Complete #1-5)** Date _____

1. **CURRENT COMPLAINTS:** Please describe how your **CURRENT** condition(s) or symptom(s) began:

_____

_____

_____

2. Who have you seen for these **CURRENT** symptoms? (If Yes, check below which apply and continue section)

___No One ___Medical Doctor ___Chiropractor ___Physical Therapist ___Other (Describe)_____

Please list any names of providers seen for this current complaint: _____

What treatment(s) did you receive and when? _____

Circle any diagnostic testing have you had for your symptoms?

(X-Rays) date:_____ (CT Scan) date:_____ (MRI) date:_____ (Other) _____

3. **PAST HISTORY:** Have you had similar symptoms in the **PAST or SIGNIFICANT injuries**? ( YES / NO ) (If Yes, continue section)

If Yes, what symptom or condition did you have in the past: _____

Was this past condition due to an accident or injury? ( YES / NO ) If yes, describe injury and approximate date: _____

_____

When was the last time you experienced those symptoms? _____

How long did those past symptoms last for? _____

Did you condition require any surgeries? ( YES / NO ) If Yes, When was the surgery: _____

Did your symptoms and condition(s) resolve? ( YES / NO ) If No, what condition remained: _____

Did you see a medical provider / chiropractor or other specialist for that past condition? ( YES / NO )

If Yes, who did you see? (Please list names of providers)

Name: _____ Specialty: MD / DC / PT Name: _____ Specialty: MD / DC / PT

Name: _____ Specialty: MD / DC / PT Name: _____ Specialty: MD / DC / PT

4. What is your occupation? _____ Are you required a disability note for your employer / teacher? ( YES / NO )

5. **Family History:** Does anyone in your immediate family (including your grandparents) have any of the conditions listed?
(Circle all that apply) **Arthritis, Asthma, Birth Defects (i.e. heart defects), Cancer, Diabetes, Genetic Conditions (i.e. Cystic Fibrosis), Heart Disease, Mental Illnesses (i.e. Alzheimer's, Parkinson's), Obesity, Osteoporosis, Seizures**

**DOCTORS NOTES:** _____

*Kyle Tetz Chiropractic Inc.—410 S. Melrose Dr. Ste 200, Vista, CA 92081—Ph: 760.630.8060*

PATIENT NAME:

# ARBITRATION AGREEMENT

**Article 1: Agreement to Arbitrate:** It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California and federal law, and not by a lawsuit or resort to court process except as California and federal law provide for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. Further, the parties will not have the right to participate as a member of any class of claimants, and there shall be no authority for any dispute to be decided on a class action basis. An arbitration can only decide a dispute between the parties and may not consolidate or join the claims of other persons who have similar claims.

**Article 2: All Claims Must be Arbitrated**: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, as to whether this agreement is unconscionable, and any procedural disputes, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the healthcare provider including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the healthcare provider and/or other licensed healthcare providers, preceptors, or interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the healthcare provider, including those working at the healthcare provider's clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the healthcare provider, and/or the healthcare provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages. This agreement is intended to create an open book account unless and until revoked.

**Article 3: Procedures and Applicable Law:** A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days, and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's equal share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit. Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder, any existing court action against such additional person or entity shall be stayed pending arbitration. The parties agree that provisions of the California Medical Injury Compensation Reform Act shall apply to disputes within this arbitration agreement, including, but not limited to, sections establishing the right to introduce evidence of any amount payable as a benefit to the patient as allowed by law (Civil Code 3333.1), the limitation on recovery for non-economic losses (Civil Code 3333.2), and the right to have a judgment for future damages conformed to periodic payments (CCP 667.7). The parties further agree that, where not in conflict with this agreement, the Arbitration Rules of ADR Services, Inc. shall govern any arbitration conducted pursuant to this Arbitration Agreement. A copy of the ADR Services rules are available on its website at www.adrservices.com or by calling 213-683-1600 to request a copy of the rules.

**Article 4: General Provision:** All claims based upon the same incident, transaction, or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

**Article 5: Revocation:** This agreement may be revoked by written notice delivered to the healthcare provider within 30 days of signature and, if not revoked, will govern all professional services received by the patient and all other disputes between the parties.

**Article 6: Retroactive Effect**: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment), patient should initial here. _____. Effective as of the date of first professional services.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

**NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.**

Patient Name (print): _____ Signature: _____ Date: _____

Parent or Guardian (print): _____ Signature: _____ Date: _____

Office Name: _____ Signature: _____ Date: _____

**ALSO SIGN THE INFORMED CONSENT ON REVERSE SIDE**

# Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures, if indicated. Any examinations or tests conducted will be carefully performed, but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including, but not limited to, hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an arterial dissection that involves an abnormal change in the wall of an artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. This occurs in 3-4 of every 100,000 people, whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately, a percentage of these patients will experience a stroke. As chiropractic can involve manually and/or mechanically adjusting the cervical spine, it has been reported that chiropractic care may be a risk for developing this type of stroke. The association with stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

*I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.*

Patient Name: _____ Signature: _____ Date: _____

Parent or Guardian: _____ Signature: _____ Date: _____

Witness Name: _____ Signature: _____ Date: _____

**ALSO SIGN THE ARBITRATION AGREEMENT ON REVERSE SIDE**

## OFFICE POLICIES / PROCEDURES AGREEMENT AND CUSTOMARY FEE SCHEDULE

### FINANCIAL ARRANGEMENTS

I understand and agree that health and accident policies are an arrangement between an insurance company carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

### INSURANCE BILLING/PAYMENT

Patients are ultimately fully responsible for services provided by our office. For your convenience, our office will make an effort to verify your insurance benefits. However, please note that verification of benefits is not guaranteed. Your insurance company makes the final determination of insurance benefits when they consider the claim. Patients are fully responsible for payment of services not authorized or covered by their insurance company. Patients that are represented by an attorney in PI cases must notify our office the same day if changing or canceling representation.

### PAYMENT ARRANGEMENTS

We understand that occasions arise when it may be necessary for you to request to be billed rather than pay at the time of service. This may include setting up a payment plan for those who may require extensive treatments. Payment is due within 30 days of the service rendered. If there are legitimate financial problems, please discuss them with our office manager prior to the 30 days so that we may find a workable solution. If an account is not paid within 30 days and no payment arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting your account. You will also be charged a monthly interest of 10% based off your principal balance until all fees are paid.

### APPOINTMENT SCHEDULING

Canceling or rescheduling appointments requires a 24 hour notice otherwise you will be charged a fee for the missed scheduled service.

### NOTICE OF PRIVACY POLICY

We are required by law to make sure your medical information is protected; give you notice describing our legal duties and privacy practices with respect to medical information about you; and follow the terms of the notice that is currently in effect. By signing below you are acknowledging that you have received our Notice of Privacy Policy.

### NOTICE OF PRIVATE PRACTICES/ BUSINESSES AND PATIENT'S FREEDOM OF CHOICE

There are separate practices/ businesses within this office. Each entity is owned and operated as separate businesses and may have separate fee schedules and different treatment techniques. I understand that each service offered at this facility are owned and operated as separate businesses and hold each business harmless from any act or omission which may occur by any of the other businesses during the course of my treatment at this facility. Circumstances may arise such as emergencies, or doctor vacation or sick leave and you may request to be treated by another doctor within this office. If you are treated by another doctor you may be charged a different fee. Patients are free to choose any doctor or organization that may be recommended by our doctors. You do not have to use the facilities at our office for treatments and we can assist you on finding an alternative locations or sources.

### KYLE TETZ CHIROPRACTIC INC. (CURRENT CUSTOMARY FEE SCHEDULE OF OUR MOST COMMON FEES)

You may request a statement or receive an insurance explanation of benefits (EOB) which will reflect services provided and the associated insurance billing codes which are shown below. According to (California Business and Professions Code 657), we offer a "Pay at Time of Service Discount" which you may qualify for. If you have any questions, please discuss them with our office manager. All fees may change without notice.

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Initial Exam** *(New Patient)* | 99201 Limited | $70.00 | **Re-Exam** *(Established Patient)* *(Treated within 3 years)* | | | 99211 Minimal | | $35.00 |
| | 99202 Expanded | $120.00 | | | | 99212 Limited | | $70.00 |
| | 99203 Detailed | $170.00 | | | | 99213 Expanded | | $120.00 |
| | 99204 Comprehensive | $260.00 | | | | 99214 Detailed | | $170.00 |
| **Chiropractic Adjustments** | 98940 | $45.00 1-2 regions | **Manual Therapies** | 97140 | $45.00 | | | |
| | 98941 | $65.00 3-4 regions | | | | **Electrical Muscle Stimulation** | 97014 | $25.00 |
| | 98942 | $83.00 5 regions | **Therapeutic Exercises** | 97110 | $50.00 / Unit | | | |
| | 98943 | $43.00 Extremities | | | | | | |
| | | | **Therapeutic Activities** | 97530 | $65.00 / Unit | **Ultrasound** | 97035 | $22.00 |
| **Massage** | 97124 | $45.00 / Unit | | | | | | |
| | Ex. 30 min = $90.00 | | **Mechanical Traction** | 97012 | $25.00 | **Neuromuscular Ed** | 97112 | $55.00 |
| **X-Rays** | **Cervical Spine** | | **Thoracic Spine** | | | **Lumbar Spine** | | |
| | 72040 | $110.00 2-3 views | 72070 | $110.00 | 2 views | 72100 | $120.00 | 2-3 views |
| | 72050 | $145.00 4 views | 72072 | $125.00 | 3 views | 72110 | $145.00 | 4 views |
| | 72052 | $170.00 5 views | | | | 72114 | $170.00 | 6 views |

**Summary Reports** ($50 per page- typically 3-6 pages) **All X-ray fees are not listed such as extremities. Ask the front desk for these fees.

PRINT NAME _____ SIGNATURE _____ DATE _____

# ProRehab Integrated Healthcare Specialists LLC

## Acknowledgement of Receipt of Notice of Privacy Practices

***This form will be retained in your medical record.***

### NOTICE TO PATIENT

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice.

**Patient Name:**_____ **Date of Birth:**_____

I acknowledge that I have **received and had the opportunity to review** the Notice of Privacy Practices on the date below on behalf of _____**ProRehab Integrated Healthcare Specialists LLC.**

I understand that the Notice describes the uses and disclosures of my protected health information by **ProRehab Integrated Healthcare Specialists LLC** and informs me of my rights with respect to my protected health information.

*Patient's Signature or that of Legal Representative*

*Printed Name of Patient or that of Legal Representative*

*Today's Date*

*If Legal Representative, Indicate Relationship*

### FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation it was not possible to obtain an acknowledgement
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ Other (please specify):_____

*Employee Name*

*Today's Date*

# ACCIDENT / INJURY QUESTIONS

**Patient:** _____ **Date:** _____

**Date of Accident:** ___ / ___ / ____ **Time of Accident:** ___: ____ **AM / PM** **Place (City/State):** _____

What was the cause of your Accident / Injury? **(Circle)** **Automobile Accident** **Work Injury** **Slip/Fall**

Describe in your own words what happened: _____

_____

_____

How did you feel immediately after the accident? (eg. Confused, dazed, dizzy, nervous, scared, nausea, etc…)

_____

Where did you immediately develop pain following the accident? _____

_____

Are there additional symptoms that developed hours, days or weeks after the accident? (eg. Headaches, tingling…)

_____

***EMERGENCY CARE***

Did you receive any medical care at the scene of the accident? (eg. Paramedics) **(YES / NO)**

Have you been to the hospital for this accident? **(YES / NO)** If yes, what hospital? _____ Date: _____

Were you taken to the hospital by ambulance? **(YES / NO)** Other: _____

Please list the areas of your body where **(X-Rays / CT / MRI)** were taken: _____

Have you been prescribed any medications for this accident? **(YES / NO)** List: _____

List ***any other Doctors' names and specialties with appointment dates*** you have seen for this accident?

_____

***AUTOMOBILE ACCIDENT***

What ***year and type*** of automobile were you driving? _____ Your approximate speed: ____ MPH

What parts of your vehicle were struck during the collision? _____

If struck by another vehicle, what type of vehicle was it? _____ Approximate speed: ____ MPH

What was the total damage estimate of your vehicle? **$**_____ Vehicle Totaled: **(YES / NO)**

Did the police arrive at the scene and was a report of the accident taken? **(YES / NO)**

Were you wearing your seatbelt? **(YES / NO)** Did the airbags deploy? **(YES / NO)**

Did you strike your head? **(YES / NO)** If yes, circle what your head hit: **Headrest, Airbag, Steering Wheel, Window, Other**

Did you strike any other body part? (eg. Knees against dashboard, etc…) **(YES / NO)** _____

Did you expect the vehicle was going to hit you? **(YES / NO)** Were you able to brace yourself? **(YES / NO)**

Was your head turned **(Right or Left)**, or looking **(Up or Down)** at the time of the impact? _____

Did you lose consciousness? **(YES / NO)** If yes, how long would you estimate you were out? _____

**Patient Signature:** _____ **Doctor Signature:** _____

Patient's Name: _____ Date of Injury: _____ Today's Date: _____

# Documenting Your Airbag Deployment Injuries

According to the history you have provided us, your recent motor vehicle collision caused your airbag supplemental restraint system to deploy. Because of the potential for serious injuries resulting from such an event, it is important that you complete the following form to the best of your recollection. Thank you for your assistance.

**A. Within moments after the time of impact, did you:** ***(circle all that apply)***

1. Black-out (lose consciousness)? If so, for approximately how long were you unconscious? _____
2. Become significantly disoriented? If so, for approximately how long were you disoriented? _____
3. Experience any nose bleeds, cuts, abrasions, bruises or burns? If so, please detail: _____
4. Have double-vision and/or blurred vision? If so, for how long? _____
5. Experience hearing loss or ringing in the ears? If so, for how long? _____
6. Experience jaw pain, facial numbness/tingling? If so, for how long? _____

Comments: _____

_____

**B. At any point *after* the impact, did you experience any of the following symptoms?** ***(circle all that apply)***

**Suspected Brain Trauma**

1. Nausea
2. Vertigo/dizziness/lightheadedness
3. Neck pain/stiffness
4. Headache
5. Photophobia (sensitivity to light)
6. Phonophobia (sensitivity to loud noises)
7. Tinnitus (ringing in the ears)
8. Impaired memory
9. Difficulty concentrating
10. Impaired comprehension or awareness
11. Prolonged, unexplained staring
12. A feeling of having a "brain fog"
13. Forgetfulness
14. Impaired logical thinking
15. Difficulty with new or abstract concepts
16. Insomnia (difficulty sleeping)
17. Fatigue
18. Apathy
19. Outburst of anger
20. Mood swings
21. Depression
22. Loss of libido (sex drive)
23. Personality change
24. Intolerance to alcohol

**Suspected TMD**

25. Clicking in the jaw
26. Popping in the jaw
27. Locking of the jaw
28. Side shift of the jaw upon maximum opening
29. Inability to open the mouth wide
30. Pain on chewing
31. Facial pain
32. Grinding your teeth
33. Jaw muscles sore upon waking
34. Chewing on one side of your mouth
35. Painful teeth
36. Loose teeth
37. Very tender muscles in the front of the neck

**Misc.**

38. Painful swallowing
39. Difficulty swallowing
40. Intolerance to strong odors
41. Decreased ability to smell things
42. Decreased ability to taste foods/drinks
43. Vision changes

Comments:

_____

_____

_____

**C. If any of the above symptoms were present before the motor vehicle collision, please list them below. Be sure to also identify their intensity, approximate date of onset, and their duration.**

_____

_____

_____

_____

_____

_____

## BACK BOURNEMOUTH QUESTIONNAIRE

Patient Name _____ Date _____

**Instructions:** The following scales have been designed to find out about your back pain and how it is affecting you. Please answer ALL the scales, and mark the ONE number on EACH scale that best describes how you feel.

1. Over the past week, on average, how would you rate your back pain?

No pain — Worst pain possible

0 1 2 3 4 5 6 7 8 9 10

2. Over the past week, how much has your back pain interfered with your daily activities (housework, washing, dressing, walking, climbing stairs, getting in/out of bed/chair)?

No interference — Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

3. Over the past week, how much has your back pain interfered with your ability to take part in recreational, social, and family activities?

No interference — Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?

Not at all anxious — Extremely anxious

0 1 2 3 4 5 6 7 8 9 10

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

Not at all depressed — Extremely depressed

0 1 2 3 4 5 6 7 8 9 10

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your back pain?

Have made it no worse — Have made it much worse

0 1 2 3 4 5 6 7 8 9 10

7. Over the past week, how much have you been able to control (reduce/help) your back pain on your own?

Completely control it — No control whatsoever

0 1 2 3 4 5 6 7 8 9 10

_____
**Examiner**

**OTHER COMMENTS:** _____

With Permission from: Bolton JE, Breen AC: The Bournemouth Questionnaire: A Short-form Comprehensive Outcome Measure. I. Psychometric Properties in Back Pain Patients. *JMPT* 1999; 22 (9): 503-510.

## NECK BOURNEMOUTH QUESTIONNAIRE

Patient Name _____ Date _____

**Instructions:** The following scales have been designed to find out about your neck pain and how it is affecting you. Please answer ALL the scales, and mark the ONE number on EACH scale that best describes how you feel.

1. Over the past week, on average, how would you rate your neck pain?

No pain — Worst pain possible

0 1 2 3 4 5 6 7 8 9 10

2. Over the past week, how much has your neck pain interfered with your daily activities (housework, washing, dressing, lifting, reading, driving)?

No interference — Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

3. Over the past week, how much has your neck pain interfered with your ability to take part in recreational, social, and family activities?

No interference — Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?

Not at all anxious — Extremely anxious

0 1 2 3 4 5 6 7 8 9 10

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

Not at all depressed — Extremely depressed

0 1 2 3 4 5 6 7 8 9 10

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your neck pain?

Have made it no worse — Have made it much worse

0 1 2 3 4 5 6 7 8 9 10

7. Over the past week, how much have you been able to control (reduce/help) your neck pain on your own?

Completely control it — No control whatsoever

0 1 2 3 4 5 6 7 8 9 10

_____
**Examiner**

**OTHER COMMENTS:** _____

With Permission from: Bolton JE, Humphreys BK: The Bournemouth Questionnaire: A Short-form Comprehensive Outcome Measure. II. Psychometric Properties in Neck Pain Patients *JMPT* 2002; 25 (3): 141-148.

## HEADACHE DISABILITY INDEX

Patient Name _____ Date _____

**INSTRUCTIONS:** Please CIRCLE the correct response:

1. I have headache: (1) 1 per month (2) more than 1 but less than 4 per month (3) more than one per week
2. My headache is: (1) mild (2) moderate (3) severe

**Please read carefully:** The purpose of the scale is to identify difficulties that you may be experiencing because of your headache. Please check off "YES", "SOMETIMES", or "NO" to each item. Answer each question as it pertains to your headache only.

| YES | SOMETIMES | NO | | |
|---|---|---|---|---|
| ____ | ____ | ____ | E1. | Because of my headaches I feel handicapped. |
| ____ | ____ | ____ | F2. | Because of my headaches I feel restricted in performing my routine daily activities. |
| ____ | ____ | ____ | E3. | No one understands the effect my headaches have on my life. |
| ____ | ____ | ____ | F4. | I restrict my recreational activities (eg, sports, hobbies) because of my headaches. |
| ____ | ____ | ____ | E5. | My headaches make me angry. |
| ____ | ____ | ____ | E6. | Sometimes I feel that I am going to lose control because of my headaches. |
| ____ | ____ | ____ | F7. | Because of my headaches I am less likely to socialize. |
| ____ | ____ | ____ | E8. | My spouse (significant other), or family and friends have no idea what I am going through because of my headaches. |
| ____ | ____ | ____ | E9. | My headaches are so bad that I feel that I am going to go insane. |
| ____ | ____ | ____ | E10. | My outlook on the world is affected by my headaches. |
| ____ | ____ | ____ | E11. | I am afraid to go outside when I feel that a headaches is starting. |
| ____ | ____ | ____ | E12. | I feel desperate because of my headaches. |
| ____ | ____ | ____ | F13. | I am concerned that I am paying penalties at work or at home because of my headaches. |
| ____ | ____ | ____ | E14. | My headaches place stress on my relationships with family or friends. |
| ____ | ____ | ____ | F15. | I avoid being around people when I have a headache. |
| ____ | ____ | ____ | F16. | I believe my headaches are making it difficult for me to achieve my goals in life. |
| ____ | ____ | ____ | F17. | I am unable to think clearly because of my headaches. |
| ____ | ____ | ____ | F18. | I get tense (eg, muscle tension) because of my headaches. |
| ____ | ____ | ____ | F19. | I do not enjoy social gatherings because of my headaches. |
| ____ | ____ | ____ | E20. | I feel irritable because of my headaches. |
| ____ | ____ | ____ | F21. | I avoid traveling because of my headaches. |
| ____ | ____ | ____ | E22. | My headaches make me feel confused. |
| ____ | ____ | ____ | E23. | My headaches make me feel frustrated. |
| ____ | ____ | ____ | F24. | I find it difficult to read because of my headaches. |
| ____ | ____ | ____ | F25. | I find it difficult to focus my attention away from my headaches and on other things. |

OTHER COMMENTS: _____

_____
Examiner

With permission from: Jacobson GP, Ramadan NM, et al. *The Henry Ford Hospital headache disability inventory (HDI)*. Neurology 1994;44:837-842.

# Upper Extremity Functional Scale

We are interested in knowing whether you are having any difficulty at all with the activities listed below because of your upper limb problem for which you are currently seeking attention. Please check (√) an answer for **each** activity.

**Today, do you or would you have any difficulty at all with:**

| Activities | Extreme Difficulty Or Unable to Perform Activity | Quite a Bit of Difficulty | Moderate Difficulty | A Little Bit of Difficulty | No Difficulty |
|---|---|---|---|---|---|
| Any of your usual work, household, or school activities | | | | | |
| Your usual hobbies, recreational or sporting activities | | | | | |
| Lifting a bag of groceries to waist level | | | | | |
| Lifting a bag of groceries above your head | | | | | |
| Grooming your hair | | | | | |
| Pushing up on your hands (e.g., from bathtub or chair) | | | | | |
| Preparing food (e.g., peeling, cutting) | | | | | |
| Driving | | | | | |
| Vacuuming, sweeping, or raking | | | | | |
| Dressing | | | | | |
| Doing up buttons | | | | | |
| Using tools or appliances | | | | | |
| Opening doors | | | | | |
| Cleaning | | | | | |
| Tying or lacing shoes | | | | | |
| Sleeping | | | | | |
| Laundering clothes (e.g., washing, ironing, folding) | | | | | |
| Opening a jar | | | | | |
| Throwing a ball | | | | | |
| Carrying a small suitcase with your affected limb) | | | | | |

Stratford P, Binkley JM, Stratford POW. Development and initial validation of the upper extremity functional index. Physiotherapy Canada Fall 2001;259-266, 281.

Patient name: _____ Signature: _____ Date: _____

Score _____/80 MDC (minimum detectable change) = 9 pts Error +/- 5 scale points

# LOWER EXTREMITY FUNCTIONAL SCALE

We are interested in knowing whether you are having any difficulty at all with the activities listed below because of your lower limb problem for which you are currently seeking attention.

Please Circle an Answer for Each Activity

**TODAY, do you or would you have any difficulty at all with:**

| | ACTIVITIES | Unable to Perform Activity | Severe Difficulty | Moderate Difficulty | Mild Difficulty | No Difficulty |
|---|---|---|---|---|---|---|
| 1 | Any of your usual work, housework, school activities | 4 | 3 | 2 | 1 | 0 |
| 2 | Your usual hobbies, recreational or sporting activities | 4 | 3 | 2 | 1 | 0 |
| 3 | Getting into or out of the bath | 4 | 3 | 2 | 1 | 0 |
| 4 | Walking between rooms | 4 | 3 | 2 | 1 | 0 |
| 5 | Putting on your shoes or socks | 4 | 3 | 2 | 1 | 0 |
| 6 | Squatting | 4 | 3 | 2 | 1 | 0 |
| 7 | Lifting an object, like a bag of groceries from the floor | 4 | 3 | 2 | 1 | 0 |
| 8 | Performing light activities around your home | 4 | 3 | 2 | 1 | 0 |
| 9 | Performing heavy activities around your home | 4 | 3 | 2 | 1 | 0 |
| 10 | Getting into or out of a car | 4 | 3 | 2 | 1 | 0 |
| 11 | Walking 2 blocks | 4 | 3 | 2 | 1 | 0 |
| 12 | Walking a mile | 4 | 3 | 2 | 1 | 0 |
| 13 | Going up or down 10 stairs (about 1 flight of stairs) | 4 | 3 | 2 | 1 | 0 |
| 14 | Standing for 1 hour | 4 | 3 | 2 | 1 | 0 |
| 15 | Sitting for 1 hour | 4 | 3 | 2 | 1 | 0 |
| 16 | Running on even ground | 4 | 3 | 2 | 1 | 0 |
| 17 | Running on uneven ground | 4 | 3 | 2 | 1 | 0 |
| 18 | Making sharp turns while running fast | 4 | 3 | 2 | 1 | 0 |
| 19 | Hopping | 4 | 3 | 2 | 1 | 0 |
| 20 | Rolling over in bed | 4 | 3 | 2 | 1 | 0 |
| | Column Totals: | | | | | |

SCORE: _____/80 = _____

**NAME:** _____ **DATE:** _____

| **FOR CLINICIAN:** Lower Extremity Functional Scale Measurement Properties |
|---|
| LEFS is scored via summation of all responses ( one answer per section) and compared to a total possible score of 80 |
| Error +/- 5 points: an observed score is within 5 points of patients "true" score |
| Minimum detectable change (MDC); 9 points; change of more than 9 points on the LEFS represents a true change |
| Minimum clinically important difference (MCID): 9 points; Clinicians can be reasonably confident that a change of greater than 9 points is..a clinically meaningful functional change. |

# ADL (ACTIVITIES OF DAILY LIVING & FUNCTIONAL ASSESSMENT)

**Patient Name:** _____ **Date of Injury:** _____ **Date:** _____

***Instructions: Please check the activities that currently bother you. Only check one box from each column.***

| ACTIVITY | ANNOYS ME ONLY | SLOWS ME DOWN | HARD TO PERFORM | UNABLE TO PERFORM |
|---|---|---|---|---|
| Bending head and neck | | | | |
| Turning head and neck | | | | |
| Bending waist – lower back | | | | |
| Twisting waist – lower back | | | | |
| Sitting | | | | |
| Standing | | | | |
| Walking | | | | |
| Driving a car | | | | |
| Riding a bicycle | | | | |
| Reaching hands over head or shoulder level | | | | |
| Household chores / cleaning / vacuuming etc. | | | | |
| Combing / Brushing hair / Bathing | | | | |
| Typing on a keyboard / Using home computer | | | | |
| Carrying objects in hand | | | | |
| Gripping objects or using wrists or hands | | | | |
| Sleeping / Lying in bed | | | | |
| Recreational or hobby activities | | | | |
| Running or jogging | | | | |
| Sports activities | | | | |
| Yard work / Gardening etc. | | | | |
| Using cell phone or tablet | | | | |
| Crouching or squatting | | | | |
| Kneeling | | | | |
| Pushing or pulling with arms /hands | | | | |
| Reading or Writing | | | | |
| Dressing myself | | | | |
| Playing with my children | | | | |
| Going up or down stairs | | | | |
| I have pain sitting and doing nothing | | | | |
| Participating in sexual activity | | | | |
| **SCORE 30 Total Choices** | | | | |
| | **(0-25%)** | **(26-50%)** | **(51-75%)** | **(76-100%)** |

**Patient Signature:** _____

**Office Notes: ADL Total** ____ **/ 30** _____

_____

_____ **Doctor Signature:** _____

# Symptoms

Patient _____ Date _____ Date of Injury _____

*Please fill in all symptoms you currently have <u>that you did not have</u> before the accident.*

## Orthopedic & Musculoskeletal Symptoms

- ☐ "Clunk" sound with neck movements
- ☐ Neck pain
- ☐ Upper back pain
- ☐ Low back pain
- ☐ Shoulder pain ☐ Left ☐ Right
- ☐ Upper arm pain ☐ Left ☐ Right
- ☐ Elbow pain ☐ Left ☐ Right
- ☐ Forearm pain ☐ Left ☐ Right
- ☐ Wrist pain ☐ Left ☐ Right
- ☐ Hand pain ☐ Left ☐ Right
- ☐ Hip pain ☐ Left ☐ Right
- ☐ Upper leg pain ☐ Left ☐ Right
- ☐ Knee pain ☐ Left ☐ Right
- ☐ Lower leg pain ☐ Left ☐ Right
- ☐ Ankle pain ☐ Left ☐ Right
- ☐ Foot pain ☐ Left ☐ Right
- ☐ Jaw pain
- ☐ Clicking in Jaw
- ☐ Pain when chewing
- ☐ Face pain
- ☐ Chest pain
- ☐ Stomach pain
- ☐ Bruise to _____
- ☐ Scrape/Cut to _____
- ☐ Other Symptom _____
- ☐ Other Symptom _____

## Neurological Symptoms

- ☐ Numb/Tingling Arm / Hand L R
- ☐ Numb/Tingling Leg / Foot L R
- ☐ Weakness Arm / Hand L R
- ☐ Weakness Leg / Foot L R

## Symptoms Associated with Injuries

- ☐ Stiffness or limited movement in joint(s)
- ☐ Headaches
- ☐ Muscle spasms/sore muscles
- ☐ Dizziness, lightheaded, woozy feeling
- ☐ Visual disturbances or vision change
- ☐ Sleep changes/disruption of patterns
- ☐ Pain radiates from one place to another
- ☐ Anxiety or nervous when driving
- ☐ Irregular Heartbeat or uneven pulse
- ☐ Feeling depressed about things
- ☐ I am taking the following medications _____

_____

## Brain/Neuropsych/MTBI/PTSD Symptoms

- ☐ I prefer being alone now (not socializing)
- ☐ I am sleepy, tired during day or doze off easily
- ☐ Upset stomach, nausea, heartburn or vomiting
- ☐ Difficulty concentrating, mind wanders easily
- ☐ I get overwhelmed easily
- ☐ Mood swings, happy one moment then sad
- ☐ Agitation (can't sit still, need to move around)
- ☐ Sadness, tearful episodes, crying easily
- ☐ Blurry vision, had to get or change glasses
- ☐ Asking people to repeat things or hearing problem
- ☐ I make wrong turns driving or can't remember time
- ☐ I get confused easily or cannot multi-task anymore
- ☐ I have difficulty finding some words when talking
- ☐ Bright lights bother me
- ☐ I cannot pay attention as long as before
- ☐ I am eating more or less than normal
- ☐ Room spins, lightheaded or woozy feeling
- ☐ Balance problems
- ☐ I feel like my head is "Foggy"
- ☐ I have forgotten computer passwords or ATM PIN
- ☐ I have to re-read things to understand what I read
- ☐ My thinking is slowed down
- ☐ Difficulty with adding/subtracting numbers
- ☐ Fear I will never be the same again
- ☐ Difficulty learning new things
- ☐ Difficulty understanding what people say to me
- ☐ Difficulty remembering or memory problems
- ☐ Cannot take on any more responsibility
- ☐ I can't make decisions as quickly as before
- ☐ Loss of libido or lack of sexual desire
- ☐ I do not feel as confident of my abilities
- ☐ I get panic attacks, fast heartbeat, nervous
- ☐ I am more irritable than usual
- ☐ Some food or drink tastes "Funny" to me now
- ☐ I get frustrated very easily
- ☐ Difficulty planning my life or organizing my work
- ☐ Flashbacks or frightening thoughts about accident
- ☐ I have had bad dreams about the accident
- ☐ I avoid places & objects that remind me about it
- ☐ I feel emotionally numb-no interest in my hobbies
- ☐ I'm feeling strong guilt, worry or depression
- ☐ I am having trouble remembering the accident
- ☐ I am easily startled since the accident - "jumpy"
- ☐ I feel tense or "on edge" most of the time
- ☐ I am having difficulty sleeping
- ☐ I get angry easily or even yell at people now


***Providers***

Kyle Tetz, DC

***Services***

Chiropractic Care

Spinal Rehab

Sports Injury Rehab

Auto Injury Rehab

Massage Therapy

Corrective Exercises

Nutritional Counseling

Weight Management

***Location***

410 S Melrose Dr.

Suite 200

Vista, CA 92081

***Contact***

P: 760.630.8060

ProRehabWellness,com

## NOTICE OF DOCTOR LIEN ON PERSONAL INJURY PROCEEDS

I hereby authorize **Dr. Kyle Tetz, DC** to furnish you, my attorney, with a full report of the examination, diagnosis, treatment, prognosis, etc. of me in regard to the accident on or about _____, for which you have been retained.

I understand that all bills incurred by me at **Dr. Kyle Tetz, DC 's** office are my responsibility to pay and I will either pay them in full at the time of service or make payment arrangements with **Dr. Kyle Tetz, DC** . I also understand that, unlike my attorney, **Dr. Kyle Tetz, DC** does not work on a contingency fee and I must pay for his services at the time of his rendering of them and that this lien is only to protect his interests in case there is a balance owing when my case is resolved.

I irrevocably instruct my attorney to withhold from my settlement or judgment any amount that, at that time, is owed **Dr. Kyle Tetz, DC** for my healthcare in connection with this accident and pay it directly and promptly to **Dr. Kyle Tetz, DC** at:

**Kyle Tetz Chiropractic Inc.**
**Dr. Kyle Tetz, DC**
**410 S. Melrose Dr. Suite 200**
**Vista CA, 92081**

I am granting **Dr. Kyle Tetz, DC** an irrevocable lien on the proceeds of my legal case and it is my intent that this lien shall be binding on my present attorney and/or any subsequent attorney which either I might hire or to whom my present attorney may assign this case. In the event I have no attorney, I hereby instruct any insurance company from which I may receive a settlement in regard to this accident to add **Dr. Kyle Tetz, DC** as a payee on the settlement draft.

| _____ | _____ | _____ |
|---|---|---|
| Print Name | Patient's Signature | Date |

I, the attorney of record for the above-named signatory in regard to the accident in question, hereby agree to abide by the terms of this lien.

| _____ | _____ | _____ |
|---|---|---|
| Attorney (Please Print) | Attorney's Signature | Date |

# Auto Insurance Information

**Patient Name:** _____
**Date of Birth:** _____

## Your Auto Insurance Company

Name of Insurance Company: _____
Name of Insured: _____
Claim Number: _____
Insurance Adjuster's Name: _____
Insurance Adjuster's Phone Number: _____

## Third Party Insurance Company (other driver)

Name of Insurance Company: _____
Name of Insured: _____
Claim Number: _____
Insurance Adjuster's Name: _____
Insurance Adjuster's Phone Number: _____

## Attorney Information

Name of Attorney: _____
Phone Number: _____

ProRehab
Integrated Healthcare Specialists LLC

# AUTHORIZATION FOR RELEASE OF RECORDS FROM:

_____

_____

_____

_____

_____

I HEREBY REQUEST AND AUTHORIZE THE RELEASE OF RECORDS TO:

**Dr. Kyle Tetz, DC**
**Kyle Tetz Chiropractic Inc.**
**410 S Melrose Dr Suite 200**
**Vista, CA 92081**
**PH/FAX: 760-630-8060**
**EMAIL: info@prorehabwellness.com**

☐ ALL RECORDS

☐ HEALTH RECORDS DATE(S):_____ TO _____

☐ X-RAY, MRI, CT REPORTS

☐ OTHER: _____

PATIENT'S NAME: _____

PATIENT'S SIGNATURE: _____

PATIENT'S DATE OF BIRTH: _____

DOCTOR'S SIGNATURE: _____