NOTICE OF DOCTOR'S LIEN

Dr. Alan Helvig
Helvig Health Chiropractic
10323 W Coggins Dr., Ste. C
Sun City, AZ 85351

RE : _____

(Patient Name)

TO : _____
_____
_____

I hereby authorize Dr. Alan Helvig to furnish my attorney and/or insurance company with a full report of his examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was involved.

I hereby authorize and direct my attorney and/or insurance company to pay directly to Dr. Alan Helvig such sums as may be due and owing him for his professional services rendered me both by reason of this accident and by reason of any other bills that are due his office and to withhold such sums from any settlement, judgment or verdict as may be necessary adequately to protect said doctor. I hereby further give a lien on my case to said doctor against any and all proceeds of any settlement, judgment or verdict which may be paid to my attorney and/or myself as the result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to Dr. Alan Helvig for all professional bills submitted by him for service rendered me and that this agreement is solely for said doctor's additional protection and in consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover said fee.

_____ _____

(Print Name) (Signature)

_____ _____

(Date) (Witness)

HELVIG HEALTH, LLC
CHIROPRACTIC PHYSICIAN

ALAN J. HELVIG, D.C.

#_____

Patient Name _____

Date of Accident _____

Insurance Company (patient)	Insurance Company (at fault ins.)
_____	_____
Claim #	Claim #
_____	_____
Adjuster Name	Adjuster Name
_____	_____
Adjuster phone and extension	Adjuster phone and extension
_____	_____
Adjuster fax #	Adjuster fax #
_____	_____
Mailing address for claims	Mailing address for claims
_____	_____
_____	_____
_____	_____
_____	_____

Attorney Name / Law office name	Mailing address
_____	_____
Contact name and number	_____
_____	_____
Fax number	_____
_____	

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Patient: _____ Date: _____

The Rivermead Post-Concussion Symptoms Questionnaire

After a head injury or accident some people experience symptoms which can cause worry or nuisance. We would like to know if you now suffer from any of the symptoms given below. As many of these symptoms occur normally, we would like you to compare yourself now with before the accident. For each one, please circle the number closest to 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:

Headaches	0	1	2	3	4
Feelings of Dizziness	0	1	2	3	4
Nausea and/or Vomiting	0	1	2	3	4
Noise Sensitivity, easily upset by loud noise	0	1	2	3	4
Sleep Disturbance	0	1	2	3	4
Fatigue, tiring more easily	0	1	2	3	4
Being Irritable, easily angered	0	1	2	3	4
Feeling Depressed or Tearful	0	1	2	3	4
Feeling Frustrated or Impatient	0	1	2	3	4
Forgetfulness, poor memory	0	1	2	3	4
Poor Concentration	0	1	2	3	4
Taking Longer to Think	0	1	2	3	4
Blurred Vision	0	1	2	3	4
Light Sensitivity, Easily upset by bright light	0	1	2	3	4
Double Vision	0	1	2	3	4
Restlessness	0	1	2	3	4

Are you experiencing any other difficulties?

1. _____	0	1	2	3	4
2. _____	0	1	2	3	4

RPQ-3: _____ RPQ-13: _____

Examiner: _____ Date: _____

HELVIG HEALTH, LLC
CHIROPRACTIC PHYSICIAN

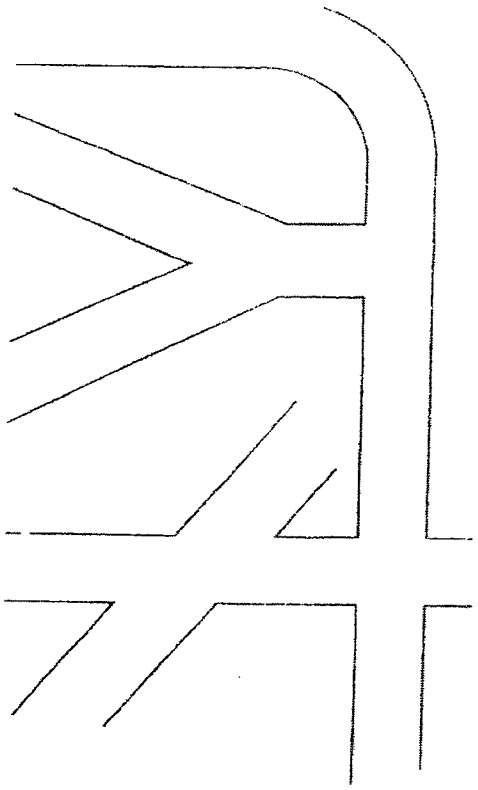
ALAN J. HELVIG, D.C.

#_____

Patient Name _____

Date of Accident _____

Draw a diagram of the cars and where they were damaged in the space provided below.



Describe the sequence of events during the accident.

_____

_____

_____

_____

_____

_____

_____

_____

Vehicle/make/model	Est. Speed
_____	_____
_____	_____
_____	_____

Make a diagram of the accident above.

1. Write down the street name and cross street.
2. Draw an arrow to indicate the direction of each car involved in the accident.
3. Write down directions such as north, south, east and west.
4. Draw in any traffic signs or signals and any street markings such as turn arrows, which are relevant to the accident.

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HELVIG HEALTH, LLC
CHIROPRACTIC PHYSICIAN

ALAN J. HELVIG, D.C.

Patient Information

Last Name_____ First Name_____

Address (Primary)_____

City_____

State_____ Zip Code_____

Address (Secondary)_____

City_____

State_____ Zip Code_____

E-mail_____

Home Phone_____ Cell Phone_____

Sex ☐ M ☐ F Age_____

Date of Birth_____

Marital Status

☐ Married ☐ Single ☐ Widowed

☐ Separated ☐ Divorced ☐ Partnered for_____ years

Occupation_____

Patient Employer_____

Spouse's Name_____

Whom may we thank for referring you?_____

Emergency Contact

In case of emergency, contact:

Name_____

Relationship to patient_____ Contact phone number_____

Patient Conditions

Reason for Visit _____

First day symptoms appeared _____

Rate the severity of your pain (circle, 0-no pain, 10-extreme pain):

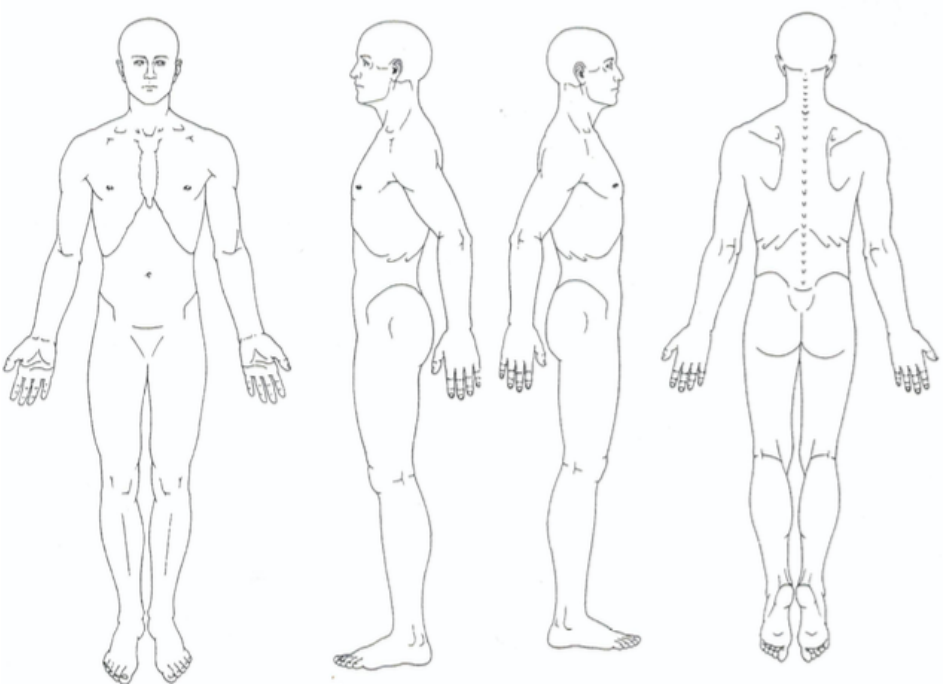
0 1 2 3 4 5 6 7 8 9 10

How often do you have this pain?

- ☐ Occasionally (less than 50% of the time)
- ☐ Intermittently (50% of the time or more)
- ☐ Constantly (approximately 100% of the time)

Please mark off the areas of your complaint on the diagram below. Please use the following symbols on the pain diagram to accurately describe your condition.

PPP	Where you experience Pain	BBB	Where you experience Burning
NNN	Where you experience Numbness	CCC	Where you experience Cramping
TTT	Where you experience Tingling		



Does it interfere with ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Movements that are difficult to perform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

Health History

What treatment have you already received for your condition? ☐ Medication ☐ Surgery

☐ Physical Therapy ☐ Chiropractic Care ☐ Other _____

Date of Last:

Physical Exam_____ Spinal X-Ray_____

Spinal Exam_____ MRI, CT-Scan, Bone Scan_____

Please circle to indicate if you have had any of the following:

AIDS/HIV	Diabetes	High Cholesterol	Prostate Problems
Alcoholism	Emphysema	Kidney Disease	Prosthesis
Anemia	Epilepsy	Liver Disease	Rheumatoid Arthritis
Arthritis	Fractures	Migraine Headaches	Stroke
Asthma	Heart Disease	Multiple Sclerosis	Thyroid Problems
Bleeding Disorders	Hernia	Osteoporosis	Tumors, Growths
Cancer	Herniated Disk	Pacemaker	Ulcers
Chemical Dependency	Herpes	Pinched Nerve	Other_____

Exercise	**Work Activity**	**Injuries/Surgeries**	**Date**
☐ None	☐ Sitting	_____	
☐ Moderate	☐ Standing	_____	
☐ Daily	☐ Light Labor	_____	
☐ Heavy	☐ Heavy Labor	_____	

Medications	**Condition Medication is Taken For**

Patient Signature_____ **Today's Date**_____

Consent to Treatment

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by Alan J. Helvig, D.C., and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed.

I have had an opportunity to discuss with Dr. Helvig and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand the results are not guaranteed.

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

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. 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:_____

Witness Signature: _____ Date: _____

Notice of Privacy Practices

Patient Acknowledgment of Receipts

This healthcare practice recognizes that every patient has the Right to Privacy concerning their personal health information. We make every effort to protect and preserve patient records in a manner that secures this information.

By signing this acknowledgment: You are only confirming that you have received a copy of our PRIVACY PRACTICES.

You do not give up any of your rights and you may choose at some point in the future to provide more specific instructions for us to follow regarding your personal health information.

I have received a copy of this office's Notice of Privacy Practices:

Printed Name:_____ Signature:_____

Today's Date:_____

NOTICE: