



Milton Chiropractic & Rehabilitation, Inc.



BAY STATE PHYSICAL THERAPY

Personal Injury Intake Form

File Number (Office Use) _____

Patient Information:

Today's Date _____

Name _____

I prefer to be called _____

Address _____

Sex **Male** **Female**

Occupation _____

Employer _____

Address _____

If minor, name of parent or guardian _____

Who should we contact in case of an emergency? _____

Relation _____

Address _____

Attorney _____

Primary Care Physician _____

Home Phone _____

Cell Phone _____

Email _____

Social Security # _____

Date of Birth _____

Height _____' _____" Weight _____ lbs

Marital Status _____

No of Children _____

_____ Phone: _____

Health Insurance Information:

Insurance Company _____ Policy number _____

Policy Holder's Name _____ Relation _____ Date of Birth _____

Accident Information:

Date _____ Time _____ AM PM

Was a traffic violation issued? **YES NO**

Location of accident (Street, Town) _____

Were there other witnesses? **YES NO**

Please explain in detail how the accident occurred _____

Was it reported to the police? **YES NO**

To whom? _____

of other passengers _____

Make/model of vehicle you were in _____

Did the impact to your vehicle come from the: **FRONT REAR RIGHT LEFT OTHER**

During impact, were you facing: **RIGHT LEFT FORWARD**

Were you **AWARE** or **SURPRISED** by the impact?

Were you the **DRIVER FRONT SEAT PASSENGER BACK SEAT PASSENGER?**

Were you wearing a seat belt? **SHOULDER HARNESS LAP HARNESS**

Patient Signature: _____ **Date:** _____



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Was the vehicle equipped with air bags? **YES NO** Did they inflate? **YES NO**
 In relation to the base of your skull, where was the headrest? **ABOVE BELOW AT BASE**
 What did your vehicle impact? **ANOTHER VEHICLE OTHER** _____
 If another vehicle, what was the make/model? _____ Direction _____ Speed _____ MPH
 Did any part of your body strike anything in the vehicle? **YES NO** Describe _____
 Did the accident render you unconscious? **YES NO** If yes, for how long? _____

Post-Injury Information:

Have you seen any other doctor(s) since the accident? **YES NO** Name _____
 When did you go? **IMMEDIATELY NEXT DAY 2 DAYS PLUS**
 How did you get there? **AMBULANCE PRIVATE TRANSPORTATION**
 Name of hospital and/or attending doctor: _____
 Was he/she a: **D.C. M.D. D.O. D.D.S.**
 Please describe any treatment you received _____
 Were X-Rays done? **YES NO** An MRI? **YES NO** CAT scan? **YES NO**
 Was medication prescribed? **YES NO** If yes, what? _____
 Have you missed any work since the accident? **YES NO** Date(s) _____
 Are your work activities restricted as a result of your injury? **YES NO**

Indicate the symptoms that are a result of this accident:

- | | | | |
|-----------------------|----------------------------|----------------------|-----------------------|
| DIZZINESS | DIFFICULTY SLEEPING | JAW PROBLEMS | NAUSEA |
| MEMORY LOSS | ARM/SHOULDER PAIN | IRRITABILITY | BACK PAIN |
| HEADACHE(S) | NUMB HANDS/FINGERS | FATIGUE | LOW BACK PAIN |
| BLURRED VISION | TENSION | CHEST PAIN | BACK STIFFNESS |
| BUZZING IN EAR | NECK PAIN | SHORT BREATH | LEG PAIN |
| EARS RINGING | NECK STIFF | STOMACH UPSET | NUMB FEET/TOES |
| OTHER _____ | | | |

Did you ever experience similar symptoms prior to the accident? **YES NO**
 Has your condition **IMPROVED WORSENERD** or **STAYED SAME** since the accident?
 Is your condition affecting your **WORK SLEEP** or **DAILY ROUTINE**? Please explain _____

Please indicate your degree of difficulty (on a scale of 1-5, with 1 being comfortable, 3 being uncomfortable, and 5 being painful) in performing the following activities:

- | | | | |
|-------------------|-------------------|----------------------|--------------|
| ___ Lying on Back | ___ Lying on Side | ___ Lying on stomach | ___ Sitting |
| ___ Standing | ___ Stretching | ___ Lovemaking | ___ Walking |
| ___ Running | ___ Sports | ___ Working | ___ Lifting |
| ___ Bending | ___ Kneeling | ___ Pulling | ___ Reaching |

How many hours are in your normal workday? _____

Please indicate your daily job duties and any activities that you are occasionally asked to perform:

- | | | | |
|-----------------|-------------------------------|----------------|-----------------|
| STANDING | OPERATING EQUIPMENT | DRIVING | SITTING |
| TWISTING | WORK W/ARMS ABOVE HEAD | WALKING | CRAWLING |
| TYPING | LIFTING | BENDING | STOOPING |

What positions can you work in with minimum physical effort, and for how long? _____

Patient Signature: _____ **Date:** _____



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Do you work with others who can help you with any heavy lifting? **YES** **NO**
While in recovery, are there any light duty tasks you could request? **YES** **NO**

Auto Insurance Information:

Insurance Company _____
Address _____
Adjustor Name _____

Policy number _____
Phone _____
Claim # _____

Patient Signature _____

Date _____



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Health History

Are you taking any of the following medications?

NERVE PILLS **PAIN KILLERS** (incl. aspirin) **MUSCLE RELAXERS** **STIMULANTS**
BLOOD THINNERS **TRANQUILIZERS** **INSULIN** **OTHER** _____

Have you ever had any of the following diseases or conditions?

HEART ATTACK/STROKE	HEART SURGERY/PACEMAKER	HEART MURMUR
CONGENITAL HEART DEFECT	MITRAL VALVE COLLAPSE	ARTIFICIAL VALVES
ALCOHOL/DRUG ABUSE	VENEREAL DISEASE	HEPATITIS
HIV+/AIDS	SHINGLES	CANCER
FREQUENT NECK PAIN	EMPHYSEMA/GLAUCOMA	ANEMIA
HIGH/LOW BLOOD PRESSURE	PSYCHIATRIC PROBLEMS	RHEUMATIC FEVER
SEVERE/FREQ. HEADACHES	KIDNEY PROBLEMS	ULCERS/COLONITIS
FAINTING/SEIZURE/EPILEPSY	SINUS PROBLEMS	ASTHMA
DIABETES/TUBERCULOSIS	DIFFICULTY BREATHING	CHEMOTHERAPY
LOWER BACK PROBLEMS	ARTIFICIAL BONES/JOINTS	ARTHRITIS

Please list any other serious medical conditions that you have or have ever had. _____

Please list anything that you may be allergic to. _____

Please list previous surgeries/treatments with dates. _____

Please list any past serious accidents with dates. _____

Is there anything else about your family health history that you feel is important to share? _____

Do you: Take supplements or vitamins? **YES** **NO** Exercise? **YES** **NO**

Are you on a special diet? **YES** **NO** Since: _____ / _____ / _____

Do you smoke? **YES** **NO** How much? _____ How long? _____

Are you wearing: **HEEL LIFTS** **SOLE LIFTS** **INNER SOLES** **ARCH SUPPORTS ?**

What is the age of your mattress? _____ Is it comfortable? **YES** **NO**

For women: Are you taking birth control? **YES** **NO**

Are you pregnant? **YES** **NO** How long? _____ Nursing? **YES** **NO**

Patient Signature _____ **Date** _____



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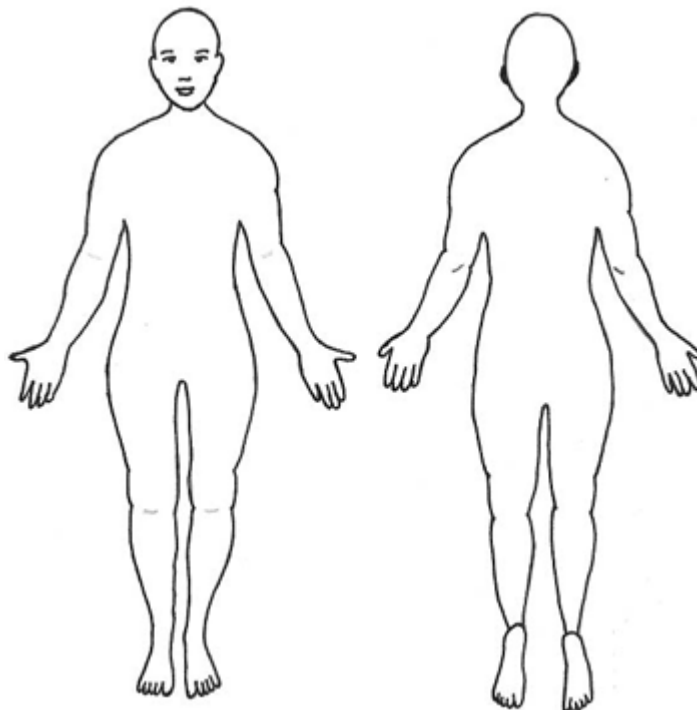


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Test	Have you had this test?	Date performed	Did you bring copy today?
X-ray	Y or N		Y or N
MRI	Y or N		Y or N
CT Scan	Y or N		Y or N
Bone Scan	Y or N		Y or N
EMG	Y or N		Y or N
Other _____	Y or N		Y or N

Please mark these drawings to show the location of your symptoms and the type of symptoms you are experiencing.

Sharp Pain /////
Achy Pain ^^^^^
Burning Pain XXXXX
Numbness 0000



Pain Scale

Please circle the number corresponding with the intensity of your symptoms. A "0" represents no pain where as a "10" represents the most severe pain imaginable.

Location: _____ 1 2 3 4 5 6 7 8 9 10

Location: _____ 1 2 3 4 5 6 7 8 9 10

Location: _____ 1 2 3 4 5 6 7 8 9 10

Patient Signature: _____ **Date:** _____



**Milton Chiropractic
& Rehabilitation, Inc.**



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Patient Information Consent Form

I understand that Milton Chiropractic / Bay State Physical Therapy may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payments, understand that have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operation if I notify the practice. I also understand that Milton Chiropractic / Bay State Physical Therapy will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Milton Chiropractic / Bay State Physical Therapy's Notice of information practices. I understand that I retain the right to revoke this consent by not signing the practice at any time.

Patient Name: _____

Signature : _____

Date: _____



**Milton Chiropractic
& Rehabilitation, Inc.**



BAY STATE
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Acknowledgement of Office Policies

The following are Milton Chiropractic and Bay State Physical Therapy's policies governing appointment scheduling, payment terms, and information release. Please read carefully and initial after each section before signing the bottom, and be sure to ask any questions you might have before signing the document.

Appointment Scheduling. We at Milton Chiropractic and Bay State Physical Therapy are glad to accept insurance assignment on your behalf in handling payment for the care you receive. However, in order to help ensure that your insurance company pays for the care you receive here, it is important that you adhere to the recommended care program. This means that if you miss several appointments without notifying our office (emergencies considered), you may be dismissed from care and your file may be closed. *We only treat those patients who want to get well.*

Consent for Treatment. I, the undersigned, give Milton Chiropractic and Bay State Physical Therapy my permission to evaluate and treat my injury. I further understand that in the course of recommended treatment, my condition may worsen on rare occasions, or injury may occur (ie. muscle spasm, rib injury, etc). Risk of injury or complications from chiropractic treatments and physical therapy are substantially lower than that associated with many medical procedures or medications given for the same symptoms. I further understand that **no guarantee or promise** has been made to me concerning the results of treatment.

Assignment of Payment. I hereby **authorize** my insurance company and/or my attorney to pay direct to Milton Chiropractic & Rehabilitation and Bay State Physical Therapy any monies due on my account for professional services rendered.

Acknowledgement and Understanding. It is further understood that I, the undersigned, **agree to pay the full amount** of the charges should my condition be such that it is not covered by my policy, or if, for any reason, the insurance company and/or my attorney refused to pay my balance at this office.

Private Health Insurance. I understand that I am responsible for whatever fees my insurance company does not pay on my claim. (Typically, this includes deductibles and/or co-payments.)

Authorization to Release Information. I **authorize** this office to release any information pertinent to my case to any insurance company or attorney to facilitate collections on my balance at this office.

Patient Requests for Records. I **authorize** the release of all medical, hospital, or surgical records pertinent to my care, including but not limited to, exams, special tests, x-rays, or lab results to this office.

Ownership. I understand that Milton Chiropractic, Bay State Physical Therapy and Massage Works! are all owned and operated by the same entity.

I certify that I have read and understand all appointment and office policies listed above.

Name (print) _____ Signature _____ Date _____

Witness (print) _____ Signature _____ Date _____



**Milton Chiropractic
& Rehabilitation, Inc.**



BAY STATE
PHYSICAL THERAPY

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

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

Uses and Disclosures

Here are some examples of how we might have to use or disclose your health care information:

- 1) Your chiropractor, physical therapist or a staff member may have to disclose your health information including all of your clinical records to another health care provider or a hospital if it is necessary to refer you to them for diagnosis, assessment, or treatment of your health condition.
- 2) Our insurance and billing staff may have to disclose your examination and treatment records and your billing records to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are potentially responsible for the payment of your services.
- 3) Your chiropractor, physical therapist and members of the staff may need to use your health information, examination and treatment records and your billing records for quality control purposes or for other administrative purposes to efficiently and effectively run our practice.
- 4) Your chiropractor, physical therapist and members of the practice staff may need to use your name, address, email, phone number, and your clinical records to contact you to provide appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. 164.520 (b)(1)(iii) (A). If you are not at home to receive an appointment reminder, a message will be left on your answering machine. You have the right to refuse to give us authorization to contact you to provide appointment reminders, information about treatment alternatives, or other health related information. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care. You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time.

Our Privacy Pledge

We have and always will respect your privacy. Other than the uses and disclosures we described above, we will not sell or provide any of your health information to any outside marketing organization.

Permitted uses and disclosures without your consent or authorization

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in these following circumstances:

- 1) We are permitted to use or disclose your health information if we are providing health care services to you based on the orders of another health care provider.



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2)

health information if we provide health care services to you as an inmate.

We are permitted to use or disclose your

3) We are permitted to use or disclose your health information if we provide health care services to you in an emergency.

4) We are permitted to use or disclose your health information if we are required by law to treat you and we are unable to obtain your consent after attempting to do so.

5) We are permitted to use or disclose your health information if there are substantial barriers to communicating with you, but in our professional judgement we believe that you intend for us to provide care.

Other than the circumstances described in the preceding five examples and under the **Uses and Disclosures** section above, any other use or disclosure of your health information will only be made with your written authorization.

Your right to revoke your authorization

You may revoke your authorization to us at any time; however, your revocation must be in writing. There are two circumstances under which we will not be able to honor your revocation request:

1) If we have already released your health information before we receive your request to revoke your authorization. 164.508(b)(5)(i)

2) If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims. If you wish to revoke your authorization please write to us at:

**Milton Chiropractic / Bay State Physical Therapy
111 Willard Street Suite 2A
Quincy, MA 02169**

Your right to limit uses or disclosures

If there are health care providers, hospitals, employers, insurers or other individuals or organizations to whom you do not want us to disclose your health information, please let us know, in writing, what individuals or organizations to whom you do not want us to disclose your health care information. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us. If we do not agree to your restrictions, you may drop your request or you are free to seek care from another health care provider.

Your right to receive confidential communication regarding your health information

We normally provide information about your health to you in person at the time you receive health-related services from us. We may also mail you information regarding your health or about the status of your account. We will do our best to accommodate any reasonable request if you would like to receive information about your health or the services that we provide at a place other than your home or, if you would like the information in a different form. To help us respond to your needs, please make any request in writing.



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Your right to inspect and copy your health information

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. We require your request to inspect and/or copy your health information to be in writing.

Your right to amend your health information

You have the right to request that we amend your health information for seven years from the date that the record was created or as long as the information remains in our files. We require your request to amend your records to be in writing and for you to give us a reason to support the change you are requesting us to make.

Your right to receive an accounting of the disclosures we have made of your records

You have the right to request that we give you an accounting of the disclosures we have made of your health information for the last six years before the date of your request.

The accounting will include all disclosures except those disclosures:

- required for your treatment, to obtain payment for your services, or to run our practice.
- made to you.
- necessary to maintain a directory of the individuals in our facility
- to individuals involved with your care.
- for national security or intelligence purposes.
- made to correctional officers or law enforcement officers.
- that were made prior to the effective date of the HIPAA privacy law.

We will provide the first accounting within any 12-month period without charge. There is a fee for any additional requests during the next 12 months. When you make your request we will tell you the amount of the fee and you will have the opportunity to withdraw or modify your request.

Your right to obtain a paper copy of this notice

If you have agreed to receive privacy notices by e-mail, you may request a paper copy of this notice at any time.

Our duties

We are required by law to maintain the privacy of your health information. We are also required to provide you with this notice of our legal duties and our privacy practices with respect to your health information.

We must abide by the terms of this notice while it is in effect. However, we reserve the right to change the terms of our privacy notices. If we make a change to the terms of our privacy agreement we will notify you in writing when you come in for treatment or by mail. If we make a change in our privacy terms the change will apply for all of your health information in our files.

Re-disclosure

Information that we use or disclose may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

Your right to complain

You may complain to us or to the Secretary for Health and Human Services if you feel that we have violated your privacy rights. We respect your right to file a complaint and will not take any action against you if you file a complaint. While you may make an oral complaint at any time, written comments should be addressed to:

Steven Windwer
111 Willard Street Suite 2A
Quincy, MA 02169



Milton Chiropractic & Rehabilitation, Inc.



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To Contact Us

If you would like further information about our privacy policies and practices please contact:

Steven Windwer
111 Willard Street Suite 2A
Quincy, MA 02169
drwindwer@miltonchiropractic.com

This notice is effective as of April 14, 2003 or Date you signed the acknowledgement that you have received this notice. This notice will expire seven years after the date upon which the record was created.



**Milton Chiropractic
& Rehabilitation, Inc.**



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Acknowledgement of Privacy Policy (HIPPA)

We are very concerned with protecting your privacy, especially in matters that concern your personal health information. In accordance with the *Health Insurance Portability and Accountability Act* of 1996 (HIPAA), we are required to supply you with a copy of our privacy policies and procedures. We encourage you to read this document carefully, for it outlines the use and limitations of the disclosure of your health information and your rights as a patient. If you ever have any questions or concerns regarding the use or dissemination of your personal health information, we would be happy to address them. I acknowledge that I have received a copy of Milton Chiropractic & Rehabilitation and Bay State Physical Therapy's *Notice of Privacy Practices for Protected Health Information*.

Patient Name Printed

Date

Patient Signature or Authorized Representative

Authorized Representative Name Printed and Relation to Patient



**Milton Chiropractic
& Rehabilitation, Inc.**



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HEALTH BENEFIT AFFIDAVIT

In accordance with Chapter 273 of the Acts of 1988, we are required to obtain your health insurance information before we can process your claim for Personal Injury Protection (PIP). Any medical expenses in excess of \$2,000 will not be paid by PIP, by **Massachusetts Law** they must be submitted to your health insurance carrier for payment. Any amount your health insurance does not pay will be submitted back to PIP for payment. It is your responsibility to inform us of any health insurance coverage or changes in health insurance coverage.

Failure to provide Milton Chiropractic / Bay State Physical Therapy with your current health insurance information could result in balances that you will be responsible for.

SECTION ONE:

I currently **have** health insurance coverage available to me.

YOUR NAME (please print): _____

HEALTH INSURANCE Co.: _____

HEALTH INS CO. ADDRESS & PHONE#:

HEALTH INS. ID # _____ GROUP# _____

SUBSCRIBERS NAME _____

SIGNATURE _____ DATE _____

SECTION TWO:

I certify that I **do not** have any health insurance and/or accident benefits available to me through any household member or myself.

SIGNATURE _____ DATE _____



Milton Chiropractic & Rehabilitation, Inc.



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Notice to Insurance Company of Assignment

To: _____

Adjustor: _____ Claim #: _____

You are instructed to pay directly to the provider at his/her office for all professional services rendered to me in this office.

This instruction to you is an assignment of my rights under medical coverage to the extent of this bill.

Any sum of money paid under this assignment shall be credited to my account and I shall be personally liable for any unpaid balance to the provider.

Pay to: Milton Chiropractic / Bay State Physical Therapy
111 Willard Street Suite 2A
Quincy, MA 02169
617 471.4491

Patient's Signature: _____ Date: _____

Patient's Name: _____

Patient's Address: _____

Witness Signature: _____

Acknowledgment of Insurance Company

This insurance company hereby acknowledges receipt of the above instruction and agrees to mail payment of services rendered directly to the office of and to the order of the provider only.

Authorized Signature: _____ Date: _____

Note: If this acknowledgement is not signed and returned to the office of the provider within 7 days, and if the patient continues under treatment after 7 days, it will be assumed and relied upon that the company has agreed to coverage, and acknowledges payment directly to the provider.



Milton Chiropractic & Rehabilitation, Inc.



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NOTICE OF IRREVOCABLE LIEN AND ASSIGNMENT OF BENEFITS AUTHORIZATION FOR RELEASE OF TREATMENT RECORDS LEGAL & EQUITABLE LIEN-ATTORNEY'S ACCEPTANCE

Name of Patient Name & Address: _____

Name of Insured (PIP): _____ Name of Insurer(s) (PIP): _____

Date of Injury/Illness: _____

Name of Insured (BI): _____ Name of Insurer(s) (BI): _____

Name of Law Office & Attorney: _____

In consideration of the agreement of the facility and provider(s) named above to provide me with injury treatment services, I hereby to the extent of my treatment bills irrevocably assign to my healthcare facility and to my Provider(s) all my right, title and interest to and in all applicable insurance and indemnification reimbursement benefits of applicable insurance companies including but not limited to: automobile PIP (Personal Injury Protection) coverage; Medical Payment Coverage, BI (Bodily Injury) liability proceeds and health care coverage to which I may be entitled to pay my Provider(s) for services rendered to treat me on and after the above date in connection with my injury or illness.

I further grant to my Provider an irrevocable Equitable Lien and an Official Legal Lien as set forth in Ch111§70A through Ch111§70D Massachusetts General Laws to and in any insurance benefits that may be due me and I furthermore authorize my Provider(s) to provide my attorney and any applicable insurance companies involved with a full report concerning my condition and treatment, including but not limited to office notes, dates of visits, and charges incurred.

I hereby authorize and direct any and all applicable insurance companies to make immediate payment directly to my said Provider(s) for all benefits and sums due me that may be due him or her upon receipt by you of my Provider's itemized statement for treatment services rendered to me.

It is further agreed that payment by any insurance company involved as herein directed to my Provider of any itemized statement shall be considered the same as if paid by the insurer directly to me.

I am aware that I remain personally responsible to my provider for the full amount of my unpaid treatment bills and further direct any Attorney representing me to withhold from the proceeds upon any final settlement or final disposition of my case an amount equal to that to pay any outstanding unpaid balance of my bills. This includes any balance due as a result of an independent medical exam that discontinued my personal injury protection benefits and/or my medical payments benefit.

Patient's Signature: _____ Date: _____

Parent or Legal Guardian (for minor): _____ Date: _____

AGREEMENT OF ATTORNEY

I hereby agree to honor the above irrevocable Lien and Assignment and pay Milton Chiropractic and/or Bay State Physical Therapy all sums received by me from insurers attributable to the provider's bills and also agree to pay the Provider any lawful balance due from the proceeds of any settlement or recovery.

Attorney's Signature: _____ Date: _____

A photocopy of this form can be accepted with the same authority as the original.

111 Willard Street Suite 2A - Quincy, MA 02169



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INDEPENDENT MEDICAL EXAMINATIONS

PATIENT NAME: _____

DATE OF INJURY: _____

As a personal injury patient of Milton Chiropractic / Bay State Physical Therapy, I understand that I am subject to an Independent Medical Examination (IME) ordered by the insurance company. It is my responsibility to notify this office of this exam and the subsequent findings of this examination. In the event of an Independent medical examination cutoff, I am responsible to notify this office. By signing below I understand that any medical bills remaining after an IME cutoff will become my responsibility and I direct my attorney to pay from the general proceeds of the settlement for medical services rendered. I do understand that I am responsible ultimately for any medical bills incurred. A copy of this original shall be considered as valid as the original.

SIGNATURE _____ DATE _____

WITNESS _____ DATE _____