Dr. Mackey's Family Chiropractic, PSC

Patient Name: ________________________________ **Case #**__________ **Date:** ___________

Address______________________ City__________________ State _______ Zip Code ___________

H. Phone _________________W. Phone_______________ Cell Phone ________________________

Email Address: ____

Sex M F Marital Status M S D W Date of Birth_____________ Age__________

Social Security #____

Occupation _____________________________ Employer ______________________________

Emergency Contact and Phone #: ____

Have you ever received Chiropractic Care? Yes No If yes, when? __________________

Name of most recent Chiropractor: ____

1. Since the Motor Vehicle Collision, have you experienced any of the following:

A. Loss of Range of Motion: yes/no
   a. What body parts: ____
B. Visual Disturbance: yes/no □ blurring l/r % of time: ___ □ floaters l/r % of time: ___ □ vision loss l/r % of time: ___ □ hypersensitivity l/r % of time: ___

C. Dizziness: yes/no % of time: ____
D. Anxiety/Depression: yes/no % of time: ____
E. Difficulty Sleeping: yes/no

2. Past Health History:

A. Surgeries:

Date	Type of Surgery
____________________	____
____________________	____
____________________	____
____________________	____
____________________	____

B. Previous Injury or Trauma: ____

Have you ever broken any bones? Which? ________________________________

C. Allergies: ____

100 Baughman Ave. Suite B, Danville, Ky 40422 Phone: 859-238-9300 Fax: 859-238-9977 © Got Doc Seminars LLC

Dr. Mackey's Family Chiropractic, PSC

3. Family Health History:

Do you or others in your family have a history of? (Please indicate all that apply)

□ Cancer □ Strokes/TIA's □ Headaches □ Heart disease □ Neurological diseases
□ Adopted/Unknown □ Cardiac disease below age 40 □ Psychiatric disease
□ Diabetes □ Other _______________ □ None of the above

4. Social and Occupational History:

A. Job description: ____

B. Work schedule: ____

C. Recreational activities: ____

D. Lifestyle:

Hobbies: ____

Level of Exercise: ____

Alcohol Use: ____

Tobacco Use: ____

Drug Use: ____

Diet: ____

5. Medications:

Medication	Reason for taking

100 Baughman Ave. Suite B, Danville, Ky 40422 Phone: 859-238-9300 Fax: 859-238-9977

© Got Doc Seminars LLC

Dr. Mackey's Family Chiropractic, PSC

Patient Name: ___________________________________ Case #___________ Date: ____________

Review of Systems

Have you had any of the following **pulmonary (lung-related)** issues?
□ Asthma/difficulty breathing □ COPD □ Emphysema □ Other _________________ □ None of the above

Have you had any of the following **cardiovascular (heart-related)** issues or procedures?
□ Heart surgeries □ Congestive heart failure □ Murmurs or valvular disease □ Heart attacks/MIs □ Heart disease/problems □ Hypertension □ Pacemaker □ Angina/chest pain □ Irregular heartbeat □ Other _________
□ None of the above

Have you had any of the following **neurological (nerve-related)** issues?
□ Visual changes/loss of vision □ One-sided weakness of face or body □ History of seizures □ One-sided decreased feeling in the face or body □ Headaches □ Memory loss □ Tremors □ Vertigo □ Loss of sense of smell
□ Strokes/TIAs □ Other ___________________________ □ None of the above

Have you had any of the following **endocrine (glandular/hormonal)** related issues or procedures?
□ Thyroid disease □ Hormone replacement therapy □ Injectable steroid replacements □ Diabetes
□ Other ___________________________________ □ None of the above

Have you had any of the following **renal (kidney-related)** issues or procedures?
□ Renal calculi/stones □ Hematuria (blood in the urine) □ Incontinence (can't control) □ Bladder Infections
□ Difficulty urinating □ Kidney disease □ Dialysis □ Other ___________________ □ None of the above

Have you had any of the following **gastroenterological (stomach-related)** issues?
□ Nausea □ Difficulty swallowing □ Ulcerative disease □ Frequent abdominal pain □ Hiatal hernia □ Constipation
□ Pancreatic disease □ Irritable bowel/colitis □ Hepatitis or liver disease □ Bloody or black tarry stools
□ Vomiting blood □ Bowel incontinence □ Gastroesophageal reflux/heartburn □ Other ________ □ None of the above

Have you had any of the following **hematological (blood-related)** issues?
□ Anemia □ Regular anti-inflammatory use (Motrin/Ibuprofen/Naproxen/Naprosyn/Aleve) □ HIV positive
□ Abnormal bleeding/bruising □ Sickle-cell anemia □ Enlarged lymph nodes □ Hemophilia
□ Hypercoagulation or deep venous thrombosis/history of blood clots □ Anticoagulant therapy □ Regular aspirin use
□ Other ____ □ None of the above

Have you had any of the following **dermatological (skin-related)** issues?
□ Significant burns □ Significant rashes □ Skin grafts □ Psoriatic disorders □ Other _________ □ None of the above

Have you had any of the following **musculoskeletal (bone/muscle-related)** issues?
□ Rheumatoid arthritis □ Gout □ Osteoarthritis □ Broken bones □ Spinal fracture □ Spinal surgery □ Joint surgery
□ Arthritis (unknown type) □ Scoliosis □ Metal implants □ Other ___________________ □ None of the above

Have you had any of the following **psychological** issues?
□ Psychiatric diagnosis □ Depression □ Suicidal ideations □ Bipolar disorder □ Homicidal ideations □ Schizophrenia
□ Psychiatric hospitalizations □ Other ______________________________ □ None of the above

Is there anything else in your past medical history that you feel is important to your care here? ______________________

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of chiropractic to provide me with chiropractic care, in accordance with this state's statutes. If my insurance will be billed, I authorize payment of medical benefits to **Dr. Mackey's Family Chiropractic, PSC** for services performed.

Patient or Guardian Signature ___________________________________ Date_____________________

100 Baughman Ave. Suite B, Danville, Ky 40422 Phone: 859-238-9300 Fax: 859-238-9977
© Got Doc Seminars LLC

100 Baughman Ave. Suite B, Danville, Ky 40422 Phone: 859-238-9300 Fax: 859-238-9977 © Got Doc Seminars LLC

Dr. Mackey's Family Chiropractic, PSC

Patient Name: ___________________________ **Case #**__________ **Date:** ___________

PATIENT HISTORY FORM

Upper Body Pain (circle: **neck, mid back**, shoulder, arm) other:__________ ☐ Left ☐ Right ☐ Whole
(put a big 'X' on the page if no upper body pain - see other side for lower body pain)

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10

- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

- Did the symptom begin suddenly or gradually? (circle one)
- When did the symptom begin? ____
  - How did the symptom begin? ____

- What makes the symptom worse? (circle all that apply):
  - nothing, any movement, bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, driving, standing, walking, running, lifting, sitting, getting up from seated position, chewing, changing positions, lying down, reading, working, exercising, laying on side in bed, other (please describe): ___________________________

- What makes the symptom better? (circle all that apply):
  - nothing, resting, ice, heat, stretching, exercise, walking, pain medication, muscle relaxers, chiropractic adjustments, massage, other (please describe): ______________________

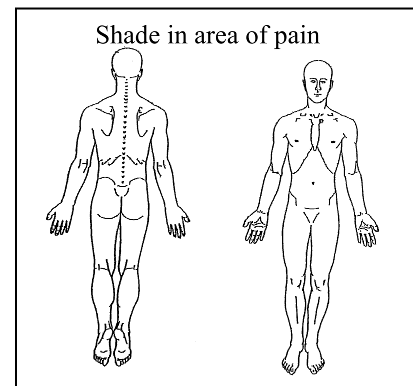
- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging Other (please describe): ____

- Does the symptom radiate to another part of your body (circle one): yes no
  - If yes, where does the symptom radiate? ________________________________

- Is the symptom worse at certain times of the day or night? (please circle)
  - No difference Morning Afternoon Evening Night Other ___________

- Have you received treatment for this condition and episode prior to today's visit?
  - No
  - Anti-inflammatory meds
  - Pain medication
  - Muscle relaxers
  - Trigger point injections
  - Cortisone injections
  - Surgery
  - Massage
  - Physical Therapy
  - Chiropractic
  - Other ____________________________

Shade in area of pain



100 Baughman Ave. Suite B, Danville, Ky 40422 Phone: 859-238-9300 Fax: 859-238-9977

© Got Doc Seminars LLC

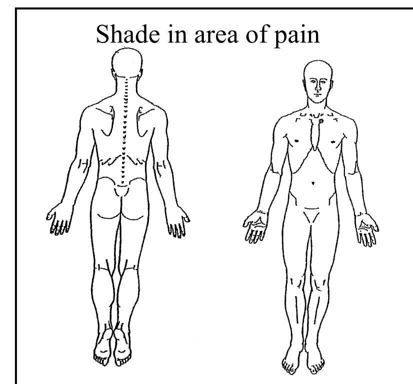
Dr. Mackey's Family Chiropractic, PSC

PATIENT HISTORY FORM

Lower Body Pain (circle: **low back,** hip, leg, knee) other: _______________ ☐ Left ☐ Right ☐ Whole
(put a big 'X' on the page if no lower body pain - see other side for upper body pain)

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- Did the symptom begin suddenly or gradually? (circle one)
- When did the symptom begin? ____
  - How did the symptom begin? ____
- What makes the symptom worse? (circle all that apply):
  - nothing, any movement, bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, driving, standing, walking, running, lifting, sitting, getting up from seated position, chewing, changing positions, lying down, reading, working, exercising, laying on side in bed, other (please describe): _________________________________
- What makes the symptom better? (circle all that apply):
  - nothing, resting, ice, heat, stretching, exercise, walking, pain medication, muscle relaxers, chiropractic adjustments, massage, other (please describe): __________________________
- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging Other (please describe): ____
- Does the symptom radiate to another part of your body (circle one): yes no
  - If yes, where does the symptom radiate? ____
- Is the symptom worse at certain times of the day or night? (please circle)
  - No difference Morning Afternoon Evening Night Other _____________
- Have you received treatment for this condition and episode prior to today's visit?
  - No
  - Anti-inflammatory meds
  - Pain medication
  - Muscle relaxers
  - Trigger point injections
  - Cortisone injections
  - Surgery
  - Massage
  - Physical Therapy
  - Chiropractic
  - Other __________________________________

Shade in area of pain



100 Baughman Ave. Suite B, Danville, Ky 40422 Phone: 859-238-9300 Fax: 859-238-9977
© Got Doc Seminars LLC

Dr. Mackey's Family Chiropractic, PSC

Patient Name: ___________________________________ Case #___________ Date: ____________

HIPAA NOTICE OF PRIVACY PRACTICES

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

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

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

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

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

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

We may use or disclose your protected health information in the following situations without your authorization. These situations included as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation. Required uses and disclosures under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW.

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

___________________________________ ________________________
Signature of Patient or Representative Date

____

100 Baughman Ave. Suite B, Danville, Ky 40422 Phone: 859-238-9300 Fax: 859-238-9977
© Got Doc Seminars LLC

100 Baughman Ave. Suite B, Danville, Ky 40422 Phone: 859-238-9300 Fax: 859-238-9977 © Got Doc Seminars LLC

Dr. Mackey's Family Chiropractic, PSC

Patient Name: ___________________________________ **Case #**___________ **Date:** ____________

Auto Accident Mechanism of Injury Form

Date of Collision: _____________________________ Hour of Accident: ___________________ AM / PM

Please describe how the collision happened: ____

____

____

____

____

Were you wearing a seatbelt? **Yes** / **No** What type: **Lap Belt** / **Shoulder Belt** / **Both**

What was your position in the car? (Circle) **Driver** / **Front Passenger** / **Left Rear** / **Right Rear**

What type and year of vehicle were you in? ____

Angle of Impact: **Front** / **Back** / **Left** / **Right** / **Other**: ______________________________________

What type and year was the other vehicle?____

What was the approximate speed of your vehicle when the accident occurred? _____________ mph

What was the approximate speed of the other vehicle when the accident occurred? ________ mph

Did the airbags deploy? **Yes** / **No**

Were you rendered unconscious as a result of the accident? **Yes / No**

In relation to the back of your head, was your headrest set: **Low** / **Middle**

Were you surprised by the impact? **Yes** / **No**

If "NO", how did you brace? **With Hands** / **With Feet**

Where was your head facing at the time of impact? **Straight Ahead** / **Left** / **Right** / **Behind**

Were you leaning forward at the time of impact? **Yes** / **No**

Was the vehicle you were in small? **Yes** / **No**

Was offending vehicle larger or heavier? **Yes** / **No**

Were you rear-ended **and** wearing a seatbelt? **Yes** / **No**

Did you feel pain immediately after the accident? **Yes** / **No**

Area(s) of Pain**:** ____

Patient Signature ____ Date ____________________

100 Baughman Ave. Suite B, Danville, Ky 40422 **Phone: 859-238-9300 Fax: 859-238-9977** © Got Doc Seminars LLC

100 Baughman Ave. Suite B, Danville, Ky 40422 Phone: 859-238-9300 Fax: 859-238-9977 © Got Doc Seminars LLC

Dr. Mackey's Family Chiropractic, PSC

Patient Name: ______________________________ **Case #**__________ **Date:** __________

Duties Under Duress Summary

Complete the following summary as it relates to your living and work duties and how the injury(s) are affecting your performance. List the day to day living duties which are painful or difficult for you to perform as a result of the injuries you sustained in the motor vehicle collision. Include those duties/responsibilities which require that you reduce the time you are capable of performing them. Include all instances where you have received lifting, stretching, bending, sitting, standing, walking or other restrictions which affect your performance.

Work

Job Description: ____

☐ Lifting ☐ Bending ☐ Sitting ☐ Walking ☐ Computer Duties

Other: ____

Studies/School

☐ Lifting ☐ Bending ☐ Sitting ☐ Walking ☐ Computer Duties ☐Studying

Other: ____

Domestic Duties

☐ Vacuuming ☐ Taking Care of Kids ☐ Cleaning ☐ Preparing Meals

Other: ____

Household Duties

☐ Yardwork ☐ Transportation ☐ Shopping ☐ Taking Out Trash

Other: ____

100 Baughman Ave. Suite B, Danville, Ky 40422 Phone: 859-238-9300 Fax: 859-238-9977
© Got Doc Seminars LLC

Dr. Mackey's Family Chiropractic, PSC

Loss of Enjoyment Summary

Complete the following summary as it relates to your lifestyle, work environment and activities which you normally would be enjoying, but are currently not enjoying, as a result of the motor vehicle collision. Include all areas which you have had to reduce the time you are capable of experiencing them. Include all instances where you have received lifting, stretching, bending, sitting, standing, walking or other restrictions which affect your participation in any of the following areas:

Work

Job Description: ______________________________

☐ Lifting ☐ Bending ☐ Sitting ☐ Walking ☐ Computer Duties

Other: ______________________________

Studies/School

☐ Lifting ☐ Bending ☐ Sitting ☐ Walking ☐ Computer Duties ☐Studying

Other: ______________________________

Domestic Duties

☐ Vacuuming ☐ Taking Care of Kids ☐ Cleaning ☐ Preparing Meals

Other: ______________________________

Household Duties

☐ Yardwork ☐ Transportation ☐ Shopping ☐ Taking Out Trash

Other: ______________________________

Sports

☐ Social ☐ Competitive ☐ Regional

Other: ______________________________

100 Baughman Ave. Suite B, Danville, Ky 40422 **Phone: 859-238-9300 Fax: 859-238-9977**
© Got Doc Seminars LLC

Dr. Mackey's Family Chiropractic
100 Baughman Ave., Suite B
Danville, KY 40422
859-238-9300 f) 859-238-9977

ASSIGNMENT OF PROCEEDS, CONTRACTUAL LIEN, AND AUTHORIZATION

(AGREEMENT)

I HEREBY DIRECT ANY AND ALL INSURANCE CARRIERS, ATTORNEYS, AGENCIES, GOVERNMENTAL DEPARTMENTS, COMPANIES, INDIVIDUALS, AND/OR OTHER LEGAL ENTITIES ("PAYERS"), WHICH MAY ELEECT OR BE OBLIGATED TO PAY BENEFITS TO ME FOR ANY MEDICAL CONDITIONS, ACCIDENTS, INJURIES, OR ILLNESSES, PAST OR FUTURE ("CONDITION"), TO PAY DIRECTLY TO, AND EXCLUSIVELY IN THE NAME OF, DR. MACKEY'S FAMILY CHIROPRACTIC, SUCH SUMS AS MAY BE OWING TO DR. MACKEY'S FAMILY CHIROPRACTIC FOR CHARGES INCURRED BY ME, INCLUDING BUT NOT LIMITED TO, CHARGES FOR TREATMENT, NARRATIVE REPORTS, DEPOSITIONS, TESTIMONY, AND ANY OTHER CHARGES INCURRED BY ME AT THE OFFICE ("CHARGES"). I FURTHER GRANT A CONTRACTUAL LIEN TO DR. MACKEY'S FAMILY CHIROPRACTIC WITH RESPECT TO MY CHARGES, APPLICABLE TO ALL PAYERS, HOWEVER, I UNDERSTAND THAT NOTHING IN THIS AGREEMENT SHALL BE CONSTRUED AS AN ELECTION BY DR. MACKEY'S FAMILY CHIROPRACTIC TO CLAIM PROTECTION UNDER ANY STATUTORY LIEN LAW. FOR THE PURPOSES OF THIS AGREEMENT, "BENEFITS" SHALL INCLUDE, BUT SHALL NOT BE LIMITED TO, PROCEEDS FROM ANY SETTLEMENT, JUDGEMENT, OR VERDICT, AS WELL AS ANY PROCEEDS RELATING TO COMMERCIAL HEALTH OR GROUP INSURANCE, DISABILITY BENEFITS, WORKER'S COMPENSATION BENEFITS, MEDICAL PAYMENTS BENEFITS, PERSONAL INJURY PROTECTION, LOST WAGES BENEFITS, LOST SERVICES BENEFITS, NO-FAULT COVERAGE, UNINSURED AND UNDERINSURED MOTORIST COVERAGE, THIRD-PARTY LIABILITY DISTRIBUTIONS, MALPRACTICE PROCEEDS, ATTORNEY RETAINER AGREEMENTS, AND ANY OTHER BENEFITS OR PROCEEDS PAYABLE TO ME FOR THE PURPOSES STATED HEREIN, REGARDLESS OF WHETHER SUCH PROCEEDS ARE RELATED TO MY CHARGES OR NOT.

I FURTHER AGREE THAT, IN THE EVENT A PAYER REFUSES TO PAY DR. MACKEY'S FAMILY CHIROPRACTIC, I HEREBY ASSIGN, INSOFAR AS PERMITTED BY LAW, ALL OF MY RIGHTS, REMEDIES, AND BENEFITS TO DR. MACKEY'S FAMILY CHIROPRACTIC TO EXTENT OF MY CHARGES, AS WELL AS ANY AND ALL CAUSES OF ACTION THAT I MIGHT HAVE AGAINST SUCH PAYER, TO PROSECUTE SUCH CAUSES OF ACTION THAT I MIGHT HAVE AGAINSTSUCH PAYER, TO PROSECUTE SUCH CAUSES OF ACTION EITHER IN MY NAME OR IN THE OFFICE'S NAME, AND TO SETTLE OR OTHERWISE RESOLVE SUCH CAUSES OF ACTION AS THE OFFICE SEES FIT.

IN THE EVENT THAT I RETAIN ONE OR MORE ATTORNEYS TO REPRESENT ME IN THIS MATTER, I WILL DIRECT EACH ATTORNEY TO ISSUE A LETTER OF PROTECTION TO THIS OFFICE REGARDING MY CHARGES. UPON ISSUANCE, I HEREBY AGREE THAT SUCH LETTER(S) OF PROTECTION CANNOT BE REVOKED OR MODIFIED WITHOUT THE EXPRESSED WRITTEN CONSENT OF THIS OFFICE. I FURTHER DIRECT EACH ATTORNEY TO PROVIDE IMMEDIATE NOTICE OF TO THE OFFICE REGARDING ANY FUNDS RECEIVED BY THE ATTORNEY RELATING TO MY ACCIDENT, TO PROMPTLY PAY SUCH OFFICE, AND TO PROVIDE A FULL ACCOUNTING OF SUCH FUNDS TO THE OFFICE UPON ITS REQUEST.

I HEREBY DIRECT ALL PAYERS TO RELEASE TO DR. MACKEY'S FAMILY CHIROPRACTIC, ANY INFORMATION REGARDING ANY COVERAGE OR BENEFITS WHICH I MAY HAVE INCLUDING, BUT NOT LIMITED TO, THE AMOUNT OF THE COVERAGE, THE AMOUNT PAID THUS FAR, AND THE AMOUNT OF ANY OUTSTANDING CLAIMS.

I AUTHORIZE THIS OFFICE TO RELEASE ANY INFORMATION REGARDING MY TREATMENT OR PERTINENT TO MY CASE(S) TO ALL PAYERS AS DEFINED ABOVE TO FACILITATE COLLECTION UNDER THIS AGREEMENT. I HEREBY DIRECT THIS OFFICE TO FILE A COPY OF THIS AGREEMENT, TOGETHER WITH ANY APPLICABLE CHARGES, WITH ANY OR ALL PAYERS, REGARDLESS OF WHETHER A CLAIM HAS BEEN ESTABLISHED WITH SAID PAYERS. I HEREBY AUTHORIZE DR. MACKEY'S FAMILY CHIROPRACTIC TO ENDORSE / SIGN MY NAME ON ANY AND ALL CHECKS LISTING ME AS A PAYEE WHICH ARE PRESENTED TO THIS OFFICE FOR PAYMENT OF AN ACCOUNT RELATING TO ME, MY SPOUSE, OR ANY OF MY DEPENDENTS. I FURTHER AUTHORIZE DR. MACKEY'S FAMILY CHIROPRACTIC TO APPLY ANY CREDIT BALANCES ON CHARGES INCURRED BY ME TO ANY OTHER OUTSTANDING CHARGES STILL OWED BY ME, MY SPOUSE, OR MY DEPENDENTS, REGARDLESS OF WHETHER THESE OTHER CHARGES ARE RELATED TO MY CONDITION.

I UNDERSTAND THAT I REMAIN PERSONALLY RESPONSIBLE FOR THE TOTAL AMOUNTS DUE DR. MACKEY'S FAMILY CHIROPRACTIC FOR THEIR SERVICES. THIS AGREEMENT DOES NOT CONSTITUTE ANY CONSIDERATION FOR THIS OFFICE TO AWAIT PAYMENTS AND IT MAY DEMAND PAYMENTS FROM ME IMMEDIATELY UPON RENDERING SERVICES AT ITS OPTION. IF THIS OFFICE MUST TAKE ANY ACTION TO COLLECT AN OUTSTANDING BALANCE ON MY ACCOUNT, I WILL BE RESPONSIBLE FOR PAYMENT AND WILL REIMBURSE DR. MACKEY'S FAMILY CHIROPRACTIC FOR ALL COSTS OF SUCH COLLECTION EFFORTS, INCLUDING, BUT NOT LIMITED TO, ALL COURT COSTS AND ALL ATTORNEY FEES.

THIS AGREEMENT SHALL NOT BE MODIFIED OR REVOKED WITHOUT THE MUTUAL CONSENT OF DR. MACKEY'S FAMILY CHIROPRACTIC AND MYSELF. I HEREBY REVOKE ANY PREVIOUSLY SIGNED AUTHORIZATIONS, WHETHER EXECUTED AT THIS OFFICE OR ANY OTHER OFFICE TO THE EXTENT THAT THE TERMS OF THOSE AUTHORIZATIONS CONFLICT WITH THE TERMS OF THIS AGREEMENT.

I AGREE THAT EACH AND EVERY PROVISION OF THIS AGREEMENT IS REASONABLY NECESSARY FOR THE PROTECTION OF THE RIGHTS AND INTERESTS OF DR. MACKEY'S FAMILY CHIROPRACTIC AND MYSELF. HOWEVER, SHOULD ANY PROVISION OF THIS AGREEMENT BE FOUND TO BE INVALID, ILLEGAL OR UNENFORCABLE, OR FOR ANY REASON CEASE TO BE BINDING ON ANY PARTY HERETO, ALL OTHER PORTIONS AND PROVISIONS OF THIS AGREEMENT SHALL, NEVERTHELESS, REMAIN IN FULL FORCE AND EFFECT.

PATIENT NAME (PLEASE PRINT):____

PATIENT SIGNATURE:____ DATE:_____/_____/______

NAME OF CUSTODIAL PARENT OR LEGAL GUARDIAN (PLEASE PRINT)____

PARENT / GUARDIAN SIGNATURE:____ DATE:_____/_____/______