Confidential Patient Health Record

***Today's Date*:**___/____/_____

How did you hear about us? ☐ Family _____ ☐ Friend _____ ☐ Co-Worker _____
☐ Close to home/work ☐ Dr. _____ ☐ Yellow pages ☐ Drove by ☐ Hospital ☐ Insurance Plan

Personal Information

Title: ☐ **Mr.** ☐ **Ms.** ☐ **Mrs.**

Last:_____ **First:**_____ **Middle:** _____

Suffix: ☐ **Jr** ☐ **Sr** ☐ **II** ☐ **III**

Birth Date: ____/____/_____ **Age:**_____ **Sex: Male / Female** **SSN:** _____

Marital Status: ☐ **Single** ☐ **Married** ☐ **Widowed** ☐ **Divorced** ☐ **Separated**

Address: _____**Apt #** _____

City: _____ **State:** _____ **Zip:** _____ **Country:** _____ **County:** _____

Home Phone: (_____) _____-_____ **ext** _____ **Work Phone:** (_____) _____-_____ **ext** _____

Cell Phone: (_____) _____-_____ **ext** _____ **Fax #:** (_____) _____-_____ **ext** _____

Email Address: _____ **Spouses Name:** _____

Emergency Contact

Last:_____ **First:**_____**Middle:**_____

Relationship: ☐ **Spouse** ☐ **Relative** ☐ **Friend** ☐ **Other** _____

Home Phone: (_____) _____-_____ **ext** _____ **Cell Phone:** (_____) _____-_____ **ext** ___

Work Phone: (_____) _____-_____ **ext** _____

Employment Information

Business Name: _____

Phone: (_____) _____-_____ **Fax #:** (_____) _____-_____

Employer's Email Address: _____

Occupation/Job Title: _____ **Job Description** _____

Current Health Condition

Unwanted Condition (Why you are here today?):_____

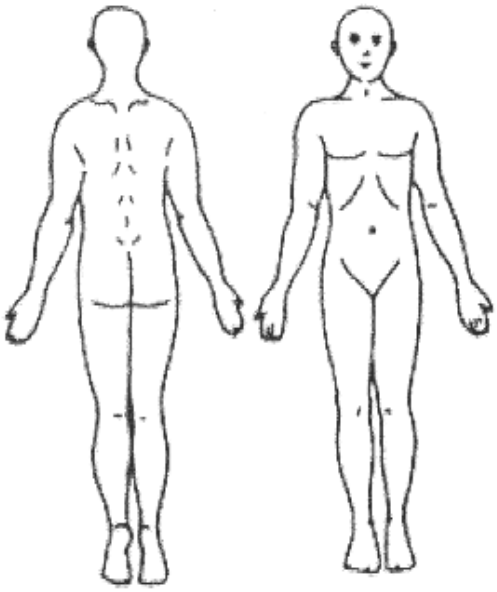
Patient Name: _____ Date:_____

Use the letters BELOW to indicate the TYPE and LOCATION of your sensations right now.

PLEASE LABEL ON THE DIAGRAM THE AREA OF DISCOMFORT

→ → → → → → →

Key: A=Ache B=Burning N = Numbness P=Pins & Needles S=Stabbing



When did this Condition BEGIN? _____/_____/_____

Has it ever occurred before? ☐ **Yes** ☐ **No. When?** _____

Is the Condition: ☐ **Auto Related** ☐ **Job Related** ☐ **Home Injury**

☐ **Slip or Fall** ☐ **Lifting** ☐ **Slept Wrong** ☐ **Unknown Cause** ☐ **Other**

Explain: _____

_____

Date of Accident: _____ **Time of Accident**: _____ **am /pm**

Condition/Pain STARTED on what Date: _____

Do you SUFFER with ANY OTHER Condition than which you are now consulting us?

_____

_____

REVIEW OF SYSTEMS -Below is a list of symptoms that may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as the problems can affect your overall course of care.

Constitutional: ☐ **I DENY having or have had any of the symptoms or problems listed below.**

☐ chills	☐ fatigue	☐ night sweats	☐ weight loss
☐ daytime drowsiness	☐ fever	☐ weight gain	

Eyes/Vision: ☐ **I DENY having any of the symptoms or problems listed below.**

☐ blindness	☐ change in vision	☐ field cuts	☐ photophobia
☐ blurred vision	☐ double vision	☐ glaucoma	☐ tearing
☐ cataracts	☐ eye pain	☐ itching	☐ wear glasses/contacts

Ears, Nose and Throat: ☐ **I DENY having any of the symptoms or problems listed below.**

☐ bleeding	☐ ear drainage	☐ hearing loss	☐ nosebleeds	☐ sore throat
☐ dentures	☐ ear pain	☐ history of head injury	☐ postnasal drip	☐ tinnitus (ringing in ears)
☐ difficulty swallowing	☐ fainting	☐ hoarseness	☐ rhinorrhea (runny nose)	☐ TMJ problems
☐ discharge	☐ frequent sore throats	☐ loss of sense of smell	☐ sinus infections	
☐ dizziness	☐ headaches	☐ nasal congestion	☐ snoring	

Respiration: ☐ **I DENY having any of the symptoms or problems listed below.**

☐ asthma	☐ coughing up blood	☐ sputum production
☐ cough	☐ shortness of breath	☐ wheezing

Patient Name: _____ Date:_____

Cardiovascular: ☐ **I DENY having any of the symptoms or problems listed below.**

☐ angina (chest pain or discomfort)	☐ high blood pressure	☐ shortness of breath with exertion or exercise
☐ chest pain	☐ low blood pressure	☐ swelling of legs
☐ claudication (leg pain/ache)	☐ orthopnea (difficulty breathing lying down)	☐ ulcers
☐ heart murmur	☐ palpitations	☐ varicose veins
☐ heart problems	☐ paroxysmal nocturnal dyspnea (waking at night w/ shortness of breath)	

Gastrointestinal: ☐ **I DENY having any of the symptoms or problems listed below.**

☐ abdominal pain	☐ diarrhea	☐ indigestion	☐ abnormal stool caliber	☐ vomiting blood
☐ belching	☐ difficulty swallowing	☐ jaundice	☐ abnormal stool color	
☐ black - tarry stools	☐ heartburn	☐ nausea	☐ abnormal stool consistency	
☐ constipation	☐ hemorrhoids	☐ rectal bleeding	☐ vomiting	

Female: ☐ **I DENY having any of the symptoms/problems and/or using any of the items listed below.**

☐ birth control	☐ cramps	☐ irregular menstruation	☐ vaginal bleeding
☐ breast lumps/pain	☐ frequent urination	☐ pregnancy	☐ vaginal discharge
☐ burning urination	☐ hormone therapy	☐ urine retention	

Male: ☐ **I DENY having any of the symptoms or problems listed below.**

☐ burning urination	☐ frequent urination	☐ prostate problems
☐ erectile dysfunction	☐ hesitancy/ dribbling	☐ urine retention

Endocrine: ☐ **I DENY having any of the symptoms or problems listed below.**

☐ cold intolerance	☐ excessive hunger	☐ goiter	☐ unusual hair growth
☐ diabetes	☐ excessive thirst	☐ hair loss	☐ voice changes
☐ excessive appetite	☐ abnormal frequency of urination	☐ heat intolerance	

Skin: ☐ **I DENY having any of the symptoms or problems listed below.**

☐ changes in nail texture	☐ hair loss	☐ itching	☐ skin lesions / ulcers
☐ changes in skin color	☐ hives	☐ paresthesias	☐ varicosities
☐ hair growth	☐ history of skin disorders	☐ rash	

Nervous System: ☐ **I DENY having any of the symptoms or problems listed below.**

☐ dizziness	☐ limb weakness	☐ numbness	☐ slurred speech	☐ tremor
☐ facial weakness	☐ loss of consciousness	☐ seizures	☐ stress	☐ unsteadiness of gait/ loss of balance
☐ headache	☐ loss of memory	☐ sleep disturbance	☐ strokes	

Psychologic: ☐ **I DENY having any of the symptoms or problems listed below.**

☐ anhedonia	☐ behavioral change	☐ convulsions	☐ memory loss
☐ anxiety	☐ bi-polar disorder	☐ depression	☐ mood change
☐ loss or change in appetite	☐ confusion	☐ insomnia	

Allergy: ☐ **I DENY having any of the symptoms or problems listed below.**

☐ anaphalaxis	☐ itching	☐ chronic nasal congestion	☐ sneezing
☐ food intolerance	☐ acute nasal congestion	☐ rash	

Hematologic: ☐ **I DENY having any of the symptoms or problems listed below.**

☐ anemia	☐ blood clotting	☐ bruising easily	☐ lymph node swelling
☐ bleeding	☐ blood transfusion	☐ fatigue	

Patient Name: _____ Date:_____

PAST HEALTH HISTORY – Fill out carefully as these problems can affect your overall course of care.

Previous Care for this Same Condition:
☐ I have not previously seen a doctor for this condition OR Fill in the information BELOW

Have you seen other doctors for THIS CONDITION? ☐ Yes ☐ No. If yes, Who? (Name) _____
Type of Treatment: _____ Was the treatment beneficial in resolving condition? ☐ Yes ☐ No

Explain: _____

Previous Chiropractic Care: **☐ I have not previously seen a Chiropractor OR Fill in the information BELOW.**

Doctor's Name: _____ Location: _____ Date of Last Visit: _____

Current Medication (s): **List ANY/ALL medications you are CURRENTLY taking. Be Specific.**

Medication	Dosage	For What Condition?	How long have you been taking this?

Childhood Illness (es): **LIST all health conditions. CIRCLE all CURRENT conditions.**

- ☐ ADD
- ☐ atopic dermatitis (eczema)
- ☐ allergies/hayfever
- ☐ anemia
- ☐ asthma
- ☐ bedwetting
- ☐ cerebral palsy
- ☐ chicken pox
- ☐ crohn's/colitis
- ☐ depression
- ☐ diabetes
- ☐ ear infections
- ☐ fetal drug exposure
- ☐ food allergies (list below)
- ☐ headaches
- ☐ hepatitis
- ☐ HIV
- ☐ measles
- ☐ mumps
- ☐ psoriasis
- ☐ rash
- ☐ scoliosis
- ☐ seizure disorder
- ☐ sickle cell anemia
- ☐ spina bifida
- ☐ other:

Adult Illness(es): **LIST all health conditions. CIRCLE all CURRENT conditions.**

- ☐ ADD
- ☐ alzheimers
- ☐ anemia
- ☐ arthritis
- ☐ asthma
- ☐ cancer
- ☐ cerebral palsy
- ☐ chicken pox
- ☐ crohn's/colitis
- ☐ CRPS (RSD)
- ☐ CVA (stroke)
- ☐ cystic kidney disease
- ☐ depression
- ☐ diabetes (insulin dep)
- ☐ diabetes (non insulin)
- ☐ eczema
- ☐ emphysema
- ☐ eye problems
- ☐ fibromyalgia
- ☐ heart disease
- ☐ hepatitis
- ☐ HIV
- ☐ hypertension
- ☐ influenzal pneumonia
- ☐ liver disease
- ☐ lung disease
- ☐ lupus erythema (discoid)
- ☐ lupus erythema (systemic)
- ☐ multiple sclerosis
- ☐ parkinson's disease
- ☐ unspecified pleural effusion
- ☐ pneumonia
- ☐ psoriasis
- ☐ psychiatric problems
- ☐ scoliosis
- ☐ seizures
- ☐ shingles
- ☐ past history of similar symptoms
- ☐ STD's (unspecified)
- ☐ suicide attempt(s)
- ☐ thyroid problems
- ☐ vertigo
- ☐ other:

Doctor: Are Child/Adult Illnesses listed contributory to the CURRENT Condition? ☐ yes or ☐ no.

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Phone: 623-252-1512 ▪ Fax: 623-251-4382

Patient Name: _____ Date:_____

Surgery (ies): **LIST All Surgical Procedures. Write the DATE of the Procedure immediately afterward.**

☐ angioplasty	☐ cosmetic	☐ hysterectomy	☐ pacemaker insertion
☐ appendectomy	☐ D & C	☐ joint reconstruction	☐ rotator cuff
☐ caesarian section	☐ dental surgery	☐ joint replacement	☐ spinal fusion
☐ cardiac catheterization	☐ gall bladder	☐ knee repair	☐ tonsilectomy
☐ carpal tunnel repair	☐ hemorrhoidectomy	☐ laminectomy	☐ other:
☐ coronary artery bypass	☐ hernia repair	☐ mastectomy	

Injury (ies): **Mark or List All Injuries. Write the DATE of the Injury immediately afterward.**

☐ back injury	☐ head injury (loss of consciousness)	☐ motor vehicle accident
☐ broken bones	☐ head injury (no loss of consciousness)	☐ soft tissue injury (mild)
☐ disability (ies)	☐ industrial accident	☐ soft tissue injury (moderate)
☐ fall (severe)	☐ joint injury	☐ soft tissue injury (severe)
☐ fracture	☐ laceration (severe)	☐ other:

Family History: **Mark all that apply below. List any specific conditions past or present after has/had:**

general family	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had:_____
father	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had:_____
mother	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had:_____
paternal grandfather	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had:_____
paternal grandmother	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had:_____
maternal grandfather	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had:_____
maternal grandmother	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had:_____
son (s)	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had:_____
daughter(s)	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had: _____
brother(s)	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had: _____
sister(s)	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had:_____

Your Doctors:

Dr. Carranza feels that it is very important to keep your doctor(s) up to date with your treatment and progress at his office. Please fill in <u>any</u> and <u>all</u> information below.

General Physician: _____
Address: _____
City / State / Zip: _____
Phone Number: _____

OB/Gnecologist: _____
Address: _____
City / State / Zip: _____
Phone Number: _____

Podiatrist: _____
Address: _____
City / State / Zip: _____
Phone Number: _____

OB/Gnecologist: _____
Address: _____
City / State / Zip: _____
Phone Number: _____

I acknowledge that I have received the Clinic's Notice of Privacy Practices for protected health information.

Patient Print Name: _____

Patient's Signature: _____ **Date:** _____

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Auto Accident Form

Patient Name _____ Today's Date ____/_____/_____

Please mark your involvement in the Auto Accident: ☐ Pedestrian ☐ Driver ☐ Passenger

What are your current symptoms? ☐ Pain ☐ Numbness ☐ Stiffness ☐ Weakness

Date of Accident ____/_____/_____

Patient was located: ☐ Driver ☐ Passenger- middle front ☐ Passenger- right front
☐ Passenger- left rear ☐ Passenger- middle rear ☐ Passenger -right rear

Patient Vehicle Type: ☐ Compact ☐ Mid-size ☐ Full-Size ☐ SUV ☐ Pick-up ☐ Motorcycle

Second Vehicle Type: ☐ Compact ☐ Mid-size ☐ Full-Size ☐ SUV ☐ Pick-up ☐ Motorcycle

Third Vehicle Type: ☐ Compact ☐ Mid-size ☐ Full-Size ☐ SUV ☐ Pick-up ☐ Motorcycle

Road Conditions: ☐ Clear ☐ Dark ☐ Dry ☐ Foggy ☐ Icy ☐ Wet

Road Type: ☐ Asphalt ☐ Concrete ☐ Dirt ☐ Gravel

Weather Conditions: ☐ Clear ☐ Cloudy ☐ Dark ☐ Foggy ☐ Icy ☐ Snowy

Were you aware the accident was going to occur? ☐ Yes ☐ No

Were you wearing a seatbelt? ☐ Yes ☐ No

Type of seatbelt? ☐ Lap belt only ☐ Lap and shoulder harness

Did your airbag deploy? ☐ Yes ☐ No

If yes, was there impact with airbag? ☐ Yes ☐ No ☐ Front Impact ☐ Side Impact

Does your car have a head rest? ☐ Yes ☐ No

What position was the head rest in? ☐ Up ☐ Middle ☐ Down

Patient's Head Position: ☐ Looking Straight Ahead ☐ Left Level ☐ Left Up ☐ Left Down
☐ Right Level ☐ Right Up ☐ Right Down ☐ Looking Up ☐ Looking Down

Collision Details

First Impact:	**☐ hit by other vehicle**	**☐ hit other vehicle**	**☐ hit by object**	**☐ hit object**
Impact Location:	**☐ front**	**☐ front-right**	**☐ front-left**	**☐ left**
☐ right	**☐ right-rear**	**☐ left-rear**	**☐ rear**	**☐ top**
Second Impact:	**☐ hit by other vehicle**	**☐ hit other vehicle**	**☐ hit by object**	**☐ hit object**
Impact Location:	**☐ front**	**☐ front-right**	**☐ front-left**	**☐ left**
☐ right	**☐ right-rear**	**☐ left-rear**	**☐ rear**	**☐ top**

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Patient Name _____ **Today's Date** ____/_____/_____

Collision Results

Body was thrown: ☐ **Forward** ☐ **Backward** ☐ **Left** ☐ **Right** ☐ **Can't Remember**

Head Hit: ☐ **airbag** ☐ **front windshield** ☐ **rearview mirror** ☐ **steering wheel**
☐ **dashboard** ☐ **back of the front seat** ☐ **side window/door** ☐ **another person's body** ☐ **headrest**

Chest Hit: ☐ **airbag** ☐ **steering wheel** ☐ **dashboard** ☐ **back of the front seat**
☐ **side window/door** ☐ **another person's body**

Shoulders Hit: ☐ **shoulder harness** ☐ **side window/door** ☐ **back of front seat** ☐ **another person's body**

Knees Hit: ☐ **steering wheel** ☐ **dashboard** ☐ **back of the front seat**
☐ **door panel** ☐ **center console** ☐ **another person's body**

Hips Hit: ☐ **steering wheel** ☐ **dashboard** ☐ **back of the front seat**
☐ **door panel** ☐ **center console** ☐ **another person's body**

Vehicle Damage

Patient Vehicle:	☐ **totaled**	☐ **significant damage**	☐ **light damage**	☐ **no damage**
Second Vehicle:	☐ **totaled**	☐ **significant damage**	☐ **light damage**	☐ **no damage**
Third Vehicle:	☐ **totaled**	☐ **significant damage**	☐ **light damage**	☐ **no damage**

Emergency Room

Did you see any of the following? ___ **Emergency Room** ___**Urgent Care** ____**Other** ____ **I didn't see any**

Facility name: _____ **Location:** _____

When were you taken to? ☐ **immediately** ☐ **later same day** ☐ **next day** ☐ **date** _____

How were you transported to the ER? ☐ **ambulance** ☐ **life flight** ☐ **private transportation**

What did the ER recommend? ☐ **no instructions** ☐ **see this clinic** ☐ **see DC**
☐ **see own doctor** ☐ **see orthopedist** ☐ **see neurologist** ☐ **prescription medication**
☐ **other:** _____

Did you have any x-rays taken? ☐ **Yes** ☐ **No**

If yes, what areas? _____

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Dr. Noe Carranza, D.C.
1805 N. 91st Ave. Suite 101
Phoenix, AZ 85037
Phone: 623-252-1512 Fax: 623-251-4382

Authorization to Use or Disclose Health Information

Patient Name: _____ Date of Birth: _____
Address: _____ Social Security #: _____
_____ Phone: (_____) _____-_____

I hereby authorize _____
to send / release photocopies of medical records and / or X-rays films and reports to:

_____

For the purposes, hereof, "Medical Records and X-ray Films" shall include all confidential HIV-related information (as defined in A.R.S. 36-661), confidential communicable disease related information (as defined in A.R.S. 36-661) confidential alcohol or drug abuse related information (as defined in 42 CFR Section 2.1 ET SEQ), and confidential mental health diagnosis / treatment information.

MEDICAL RECORDS REQUESTED:

☐ **All medical records of the past two (2) years treatment.**

☐ **The following described records only: _____**

RADIOLOGY / IMAGING RECORDS REQUESTED:

☐ **All available**

☐ **The following films / areas only: _____**

I have given my consent freely and without coercion. I may revoke this authorization at any time provided I notify Carranza Chiropractic and Sports Therapy in writing to that effect. I understand that any release which was made prior to my revocation in compliance with this authorization shall not be constituted a breach of my rights of confidentiality. I understand that a photocopy of this authorization is considered acceptable in lieu of the original.

_____ _____
Patient Signature **Date**

_____ _____
Parent / Legally Authorized Representative **Date**

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1805 N. 91st Ave. Suite 101 Phoenix, AZ 85037
Phone: 623-252-1512 Fax: 623-251-4382

Date _____

I, _____
(print patient's name)

authorize the performance upon myself of the following procedures: Chiropractic manipulation, hot/cold packs, electrical muscle stimulation, interferential therapy, and ultrasound to be performed by or under the direction of Dr. Noe Carranza as clinically indicated.

I also consent to the performance of other diagnostic and therapeutic procedures in addition to or different from those stated above, whether or not arising from presently unforeseen conditions, that the above-named doctor, associates or assistants, may consider necessary or advisable in the course of my health care.

The nature and purpose of the procedures, possible alternatives, the risks involved, the possible consequences, and the possibility of complications have been explained to me by the above-named doctor and/or his associates and assistants.

I acknowledge that no guarantee or assurance of the results that may be obtained from the procedure has been given by the above-named doctor, his associates or assistants.

Date _____ Signature _____

Witness _____ Relationship _____

Synergy Spine & Sport, LLC

Consent for Purposes of Treatment, Payment & Healthcare Operations

In this document, "I" and "my" refer to the patient and "Chiropractor" refers to Synergy Spine & Sport, LLC.

I consent to the use or disclosure of my protected health information by Chiropractor for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Chiropractor. I understand that analysis, diagnosis or treatment of me by Chiropractor may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or healthcare operations of the practice. Chiropractor is not required to agree to the restrictions that I may request. However, if Chiropractor agrees to a restriction that I request, the restriction is binding on Chiropractor.

I have the right to revoke this consent, in writing, at any time, except to the extent that Chiropractor has taken action in reliance on this Consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I will be provided with a copy of the Notice of Privacy Practices of Chiropractor upon my request and understand that I have a right to review the Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Chiropractor. This Notice of Privacy Practices also describes the rights and duties of the Chiropractor with respect to my protected health information.

Chiropractor reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of Chiropractor and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ _____

Signature of Patient or Personal Representative | Printed Name of Patient

_____ _____

Date of Signing | Description of Personal Representative's Authority

Date(s) of Service:
Account Balance:

LIEN-MEDICAL

AGREEMENT BY PATIENT GRANTING *SYNERYGY SPINE & SPORT, LLC* LIEN
AND PROMISING TO PAY *SYNERYGY SPINE & SPORT, LLC* FOR MEDICAL SERVICES

Patient Name: **DOB:**

Address: **City:** **State: AZ** **ZIP:**

Date of Accident:

THIS IS A LEGAL DOCUMENT READ THE FOLLOWING CAREFULLY

I,_____do hereby acknowledge and grant to *SYNERYGY SPINE & SPORT, LLC* A LIEN as surety for payment for any and all medical services already rendered to me or to be rendered on my behalf, the AMOUNT of any said LIEN to be equal to the total dollar amount already billed or to be billed by SYNERYGY SPINE & SPORT, LLC for ANY and ALL medical services incurred and provided to me as a result of the accident, injury or illness relating to the above. I authorize and direct you, my attorney/insurance carrier, to pay directly to SYNERYGY SPINE & SPORT, LLC such sums as may be due and owing them for the service rendered to me. This LIEN shall be effective against ANY and ALL payment(s), settlement(s), judgment(s), award(s), claim(s) or verdict(s)made by me or to me, entered on my behalf, or agreed to by my legal representative, which relate(s) to the above-numbered claim(s), accident, injury, or illness, whether or not said payments are made by 3rd party payers and/or 1st party payers under the provisions of any first party agreements which inures to my benefit, including liability, medical payment, health insurance, uninsured and under insurance benefits. I UNDERSTAND that I am, and continue to be, PERSONALLY RESPONSIBLE for ANY and ALL MEDICAL BILLS presented to me by SYNERYGY SPINE & SPORT, LLC, and that this agreement granting SYNERYGY SPINE & SPORT, LLC a LIEN is made for valuable consideration received by me from SYNERYGY SPINE & SPORT, LLC i.e .there agreement to await payment for said medical services until said payment(s), settlement(s), judgment(s), award(s), claim(s) or verdict(s) is/are received or entered, OR until a REASONABLE TIME has passed since said medical service(s), whichever occurs FIRST, I FURTHER ACKNOWLEDGE that even if I do not receive any monies or payments as a result of my accident or illness claim(s), I HEREBY AGREE that I still owe SYNERYGY SPINE & SPORT, LLC and hereby PROMISE TO PAY SYNERYGY SPINE & SPORT, LLC in a timely manner for all medical services rendered by them to me. This PROMISE TO PAY for medical services is NOT contingent upon any payment(s), settlements), judgment(s), award(s), claim(s) or verdict(s) which I may receive. I authorize SYNERYGY SPINE & SPORT, LLC to sign my name to any check written in both our names where such checks are in payment for its services regarding my injury. I hereby agree that I shall not submit any of the medical bills arising out of this lien for payment to any government sponsored health plan including, but not limited to, Medicare and AHCCCS unless it is agreed by you, SYNERYGY SPINE & SPORT, LLC, to do so. Finally, this confirms that as a special consideration to you, SYNERYGY SPINE & SPORT, LLC, I agree that I will not seek to have you pay or share in (or be required to pay any proportional share of) any of the collection costs, including attorney fee and costs incurred by me in obtaining the common fund recovery(the settlement, judgment, or award as to my third party claim for my accident injuries) from which you are likely to be paid as authorized pursuant to LaBombard v.Samaritan Health Systems, 195 AZ 543, 991 P .2d 446(App. 1998). Instead, **I agree to pay the full amount** of the reasonable treatment billings of you, SYNERYGY SPINE & SPORT, LLC, for treatment of my accident-related injuries, without any reduction for any proportional share of my legal fees and costs in obtaining the common fund recovery, and without reduction of your reasonable charges for any other reason [to the full extent my recovery allows]. Also, this lien is enforceable under AZ law pursuant to ARS 33-931 et al. It is also enforceable by creating a personal contract between SYNERYGY SPINE & SPORT, LLC and you and your lawyer and provides guarantees and security for payment SYNERYGY SPINE & SPORT, LLC bill for services by you and your attorney. This consensual lien and assignment is to continue, enforce, and be binding if I should decide to change physicians and/or attorneys in the future. I have read, fully understand, and hereby agree to this document, and hereby sign with the full intent that I be legally bound to the terms promises and conditions contained therein.

Synergy Spine & Sport, LLC
1805 N. 91st Ave. Suite 101
Phoenix, AZ 85037
P: (623)-252-1512 F: (623) 251-4382

(Signed) _____ 2015

Date: _____