Khoury Chiropractic, Inc.

640 Washington Street
Dedham, MA 02026
(781) 329-3344

Wassim G. Khoury, D.C.
Dawn-Marie Khoury, D.C., D.I.C.C.P.

PRIVACY NOTICE ACKNOWLEDGEMENT

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 Khoury Chiropractic Inc.'s *Notice of Privacy Practices for Protected Health Information.*

Patient Name Printed _____ Date _____

Patient Signature _____

Witness Name Printed _____ Date _____

Witness Signature _____

Our purpose at The Khoury Centre is to help as many people as possible achieve maximum health through chiropractic care, guidance, and education. Insurance regulations prohibit us from discounting or negotiating co-pays, co-insurances, deductibles, and other fees and charges. All fees for services are payable at the time they are rendered. We accept cash, checks, Visa, MasterCard, etc... Verification of your benefits prior to your visit is your responsibility and is not a guarantee of payment, the patient is responsible for all bills incurred at this office.

We will bill your insurance company for their portion of the bill if we are in their provider network. All patients are expected to supply this office with any and all information necessary to file and bill your claims. If claims are denied due to lack of insurance coverage for any reason, payment of any balance is the responsibility of the patient. Please note that insurance companies will only provide reimbursement for services which they deem medically necessary and will not provide coverage for treatment that is considered wellness care, maintenance care, or for chronic conditions. Any checks sent to you from your insurance company for services rendered in this office must be brought into our office within 3 days.

I hereby authorize the Doctor to examine and diagnose my condition as he or she deems appropriate.

Patient Signature _____ Date _____

KHOURY CHIROPRACTIC
CENTRE FOR HEALTH AND WELLNESS

Confidential Patient Health Record
PERSONAL HISTORY

Name: _____ Date of Birth: _____ Age: ____ Sex: □ M □ F

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Height: _____ Weight: _____ Race: _____ Ethnicity: _____

Employer: _____ (Circle one)

Type of Work: _____ Single Married Widowed Divorced Separated

Email: _____ Name of Emergency Contact: _____

Referred to this office by: _____ Phone number of emergency contact: _____

CURRENT HEALTH CONDITION

Reason for visit: _____

Is this condition: □ Job related □ Auto accident □ N/A

When did this condition begin? _____ Has the condition occurred before? □ Yes □ No

Other doctors seen for this condition: □ Yes □ No If yes, who? _____

Type of treatment: _____ Results: _____

Previous chiropractic care: □ None □ Doctor's name & date of last visit: _____

Name of Primary Care Physician (PCP): _____

PCP address: _____

Please list your current medications, dosage, date started, and prescribing doctor.

_____

_____

Please list any surgeries that you have had. Please include date and result of surgery.

_____

_____

Please list any diagnoses that you have received. Please include date of diagnosis.

_____

_____

Have you had any tests in the last year (lab, x-ray, MRI etc)? Please list test and result.

_____

_____

Immediate Family History – Please list family member & condition:

Relationship	Disease(s) or condition(s)	Deceased?	Cause of death
		□ Yes □ No	
		□ Yes □ No	
		□ Yes □ No	
		□ Yes □ No	

Do you smoke? □ Yes □ No If yes, how often: _____ Do you drink coffee? □ Yes □ No If yes, how often: _____

Do you drink alcohol? □ Yes □ No If yes, how often: _____ Do you wear a shoe lift/orthotics? □ Yes □ No

Do you use drugs? none recreationally addicted Do you exercise? □ Yes □ No If yes, how often: _____

KHOURY CHIROPRACTIC
CENTRE FOR HEALTH AND WELLNESS

Confidential Patient Health Record

"GEORGE'S CEREBROVASCULAR CRANIOCERVICAL FUNCTION TEST"

Instructions: Please check the correct response.

Historical Information

- Have you ever been diagnosed or told you have any of the following?
  1. High Blood Pressure (hypertension) □ Yes □ No
  2. Hardening of the arteries (arteriosclerosis) □ Yes □ No
  3. Diabetes □ Yes □ No
  4. Heart or blood vessel diseases □ Yes □ No
  5. Bone spurs on the neck bones (cervical spondylosis) □ Yes □ No
  6. Whiplash injury (flexion-extension injury) (cervical spine) □ Yes □ No
  7. Have any of your relatives suffered a stroke? □ Yes □ No
  8. Were you ever a smoker? If yes, from _____ to _____ □ Yes □ No
  9. Do you take any medications on a regular basis? □ Yes □ No
     - You will be asked to list these on page 3
  10. (Women Only) Have you ever taken oral Contraceptives? □ Yes □ No
     - If yes, from _____ to _____

- Have you ever had any of the following, even short, temporary attacks, in the last year?
  1. Blurred Vision □ Yes □ No
  2. Double Vision □ Yes □ No
  3. Diminished or partial loss of vision in one or both eyes? □ Yes □ No
  4. Complete loss of vision in one or both eyes? □ Yes □ No
  5. Ringing, buzzing or any noise in the ear(s)? □ Yes □ No
  6. Hearing loss in one or both ears? □ Yes □ No
  7. Slurred speech or other speech problems? □ Yes □ No
  8. Difficulty swallowing? □ Yes □ No
  9. Dizziness? □ Yes □ No
  10. Temporary lack of understanding? □ Yes □ No
  11. Loss on consciousness, even momentary blackouts? □ Yes □ No
  12. Numbness or loss of sensation in the face, fingers, hand, arms, legs, or any other parts of your body? □ Yes □ No
  13. Any other abnormal sensations in any part of your body? □ Yes □ No
  14. Weakness, clumsiness, or loss of strength in the face, finger, hands, arms, or legs? □ Yes □ No
  15. Sudden collapse without loss of consciousness? □ Yes □ No

KHOURY CHIROPRACTIC
CENTRE FOR HEALTH AND WELLNESS

Below is a list of diseases which may seem unrelated to the purpose of your appointment; however, these questions must be answered carefully as these problems can affect your overall course of care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD and write in approximately when:

- ☐ Pneumonia
- ☐ Rheumatic Fever
- ☐ Polio
- ☐ Tuberculosis
- ☐ Whooping Cough
- ☐ Anemia
- ☐ Measles
- ☐ Mumps
- ☐ Smallpox
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Cancer
- ☐ Heart Disease
- ☐ Thyroid
- ☐ Influenza
- ☐ Pleurisy
- ☐ Arthritis
- ☐ Epilepsy
- ☐ Mental Disorders
- ☐ Lumbago
- ☐ Eczema

Have you been tested HIV Positive? ☐ Yes ☐ No

CHECK ANY OF THE FOLLOWING YOU HAVE HAD IN THE PAST SIX MONTHS:

MUSCULO-SKELETAL CODE
- ☐ Low Back Pain
- ☐ Pain Between Shoulders
- ☐ Neck Pain
- ☐ Arm Pain
- ☐ Joint Pain/Stiffness
- ☐ Walking Problems
- ☐ Difficult Chewing/Clicking Jaw
- ☐ General Stiffness
- ☐ Gas/Bloating After Meals
- ☐ Heartburn
- ☐ Black/Bloody Stool
- ☐ Colitis

NERVOUS SYSTEM CODE
- ☐ Nervous
- ☐ Numbness
- ☐ Paralysis
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Confusion/Depression
- ☐ Fainting
- ☐ Convulsions
- ☐ Headaches

GASTRO-INTESTINAL CODE
- ☐ Poor/Excessive Appetite
- ☐ Excessive Thirst
- ☐ Frequent Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Liver Problems
- ☐ Gall Bladder Problems
- ☐ Weight Trouble
- ☐ Abdominal Cramps

GENITO-URINARY CODE
- ☐ Bladder Trouble
- ☐ Painful/Excessive Urination
- ☐ Discolored Urine

C-V-R CODE
- ☐ Chest Pain
- ☐ Short Breath
- ☐ Blood Pressure Problems
- ☐ Irregular Heartbeat
- ☐ Heart Problems
- ☐ Lung Problems/Congestion
- ☐ Varicose Veins
- ☐ Ankle Swelling
- ☐ Stroke

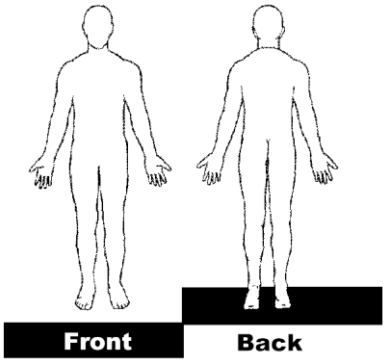
EENT CODE
- ☐ Vision Problems
- ☐ Dental Problems
- ☐ Sore Throat
- ☐ Earaches
- ☐ Hearing Difficulty
- ☐ Stuffed Nose

MALE/FEMALE CODES
- ☐ Menstrual Irregularity
- ☐ Menstrual Cramps
- ☐ Vaginal Pain/Infection
- ☐ Breast Pain/Lumps
- ☐ Prostate/Sexual Dysfunction
- ☐ Other Problems

_____
_____

FEMALES ONLY
When was your last period?
_____
Are you Pregnant?
☐ Yes ☐ No

GENERAL CODE
- ☐ Fatigue
- ☐ Allergies
- ☐ Loss of Sleep
- ☐ Fever



Please outline on the diagram the area of your discomfort

The above health history and information is complete and accurate. If a new symptom or condition arises during my treatment, I will notify the doctor as soon as possible.

_____ _____
Patient Signature Date

KHOURY CHIROPRACTIC
CENTRE FOR HEALTH AND WELLNESS

KHOURY CHIROPRACTIC INC.

INFORMED CONSENT

State law requires us to obtain your informed consent prior to examination and treatment. What you are being asked to sign is simply a confirmation that we have discussed the following:

The primary purpose of treatment by Doctor of Chiropractic is to correct subluxations, which will restore normal nervous system function and allow the body to heal naturally.

Treatment

The results of treatment cannot be guaranteed, but most of our patients improve when their treatment plan is followed as directed. You are solely responsible for your health and recovery.

Doctors: We are fortunate to have two highly skilled doctors in this practice; Dr. Wassim Khoury, and Dr. Dawn-Marie Khoury. Regardless of which doctor you see initially we encourage you to see both doctors during the early stages of your care. Although you may prefer one doctor's treatment over another's you won't know this unless you have seen each of them at least once. It is also important so that all the doctors in the practice are familiar with your case and in the event of doctor illness or vacation your care will have the continuity needed to reach the best possible outcome.

The Chiropractic Adjustment: We do not offer to diagnose or treat any condition other than the subluxation and neuromusculoskeletal disorders. We will inform you of any other abnormalities found during examination and will refer you to another practitioner for diagnosis and treatment of these abnormalities. We will use our hands to analyze the spine in order to locate vertebral subluxations. If subluxations are found, we will adjust these regions by using gentle forces with the hands to provide mobility to the area in order to facilitate correction of the subluxations. You may hear an audible "pop" or "click," this is air being released from the joint space.

Adjunctive Treatment: For some cases, this office finds it necessary to use adjunctive therapy in order to facilitate correction of vertebral and/or extremity subluxations. These therapies may include electric modalities, ice, heat, exercise rehabilitation, nutritional or lifestyle modifications.

The Material Risks

As with any health care procedure, there are certain complications that may arise due to a chiropractic adjustment. This office has never experienced any of these complications due to our gentle and precise adjusting techniques. These material risks are as follows: soft tissue injury, muscle or ligament sprain/strain, fracture, and stroke.

None of the previously mentioned risk factors have ever occurred in this office. It is estimated that the probability of stroke occurring is 1 in 5.85 million; about the same as getting struck by lightning (Haldeman et al., Canadian Medical Association Journal, Oct 2001.) Fractures may occur if a patient has some underlying weakness of the bones, which we check for during your history, examination, and x-ray analysis. Due to the rarity of occurrence of the previously mentioned risk factors, **statistics of their probability are equal to or less than 1 in a million.**

The risks associated with adjunctive therapy such as ice, heat, or electric modalities may include a skin reaction, such as burns or redness. However, we always take great precaution to protect your skin and test your sensitivity before applying modalities. **Patient burns have never occurred in this office.**

It is common after an adjustment, as well as after traction, massage therapy, exercise, in fact almost any healthcare treatment, to experience soreness in the region being adjusted. These symptoms are called recovery symptoms and usually subside after the first few adjustments. If this occurs, you should apply ice to the region for 15-20 minutes each hour with a damp towel between the ice and the skin.

Associates and Assistants

In this office we use trained staff personnel to assist the doctor with portions of your examination and treatment. Occasionally when the doctor is out of town or unavailable, another doctor will treat you.

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CENTRE FOR HEALTH AND WELLNESS

Treatment Options

Medication: Prescription and non-prescription medication, such as non-steroidal anti-inflammatories, painkillers, or muscle relaxers may be used to relieve symptoms, such as pain, muscle spasm and swelling. However, medication can only mask the symptoms related to subluxation complexes and cannot correct the cause of this problem. Professional literature describes highly undesirable effects from long-term use of prescription and non-prescription pain medications. Some of these effects include: kidney failure, ulcers, gastrointestinal toxicity, stomach bleeding, congestive heart failure, diverticular disease, and even death in 16,500 people per year (Wolfe, New England Journal of Medicine, 1999). Doctors of Chiropractic do not prescribe medication.

Surgery: Surgery is always a possibility, but the expense, danger, and ineffectiveness of such treatment is more a probability than a possibility. Adverse reactions to anesthesia, doctor caused mishaps, or infection may result.

Physical Therapy: Physical therapy is effective to stretch and strengthen muscles in the area of involvement. However, if a joint is out of alignment and muscles are strengthened to support the misaligned position; your condition may be complicated further and may in fact worsen. Physical therapy has been shown to be more effective for stabilization and prevention of subluxation complexes when engaged in *after* a phase of chiropractic treatment. When used as a second phase of care, physical therapy will strengthen muscles to stabilize the spine or joint in its correctly aligned position.

Non-Treatment

Remaining untreated can result in adhesion/calcium formation in joints, increased pain, increased muscle spasm and tightness, and reduction in associated joint mobility. These processes in turn can facilitate such conditions such as arthritis and disc degeneration and may in fact make treatment more difficult and less effective the longer it is postponed. The probability is very high that prolonged non-treatment will complicate a later exacerbation and reduce the chances of future correction and rehabilitation.

THE DOCTOR HAS EXPLAINED TO THE RISKS THAT CAN BE ASSOCIATED WITH THE CHIROPRATIC EXAMINATION AND TREATMENT. I UNDERSTAND THESE RISKS AND HAVE DISCUSSED ANY QUESTIONS OR CONCERNS WITH THE DOCTOR.

I HEREBY STATE THAT I HAVE READ THIS CONSENT FORM, AND IT MAY BE USED THROUGHOUT MY TREATMENT IN THIS OFFICE. HAVING BEEN INFORMED OF THE RISKS, I HEREBY GIVE MY CONSENT TO TREATMENT.

_____ _____

Patient Name Printed Date

_____

Patient Signature

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CENTRE FOR HEALTH AND WELLNESS

ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

Please read the following updated policies initial next to each notice and sign the bottom, in signing you acknowledge you have received and understand this notice. A copy can be provided upon request.

Note: Insurance may not always pay for everything, even some care that you or your health care provider have good reason to think you need. You may choose not to receive services that may cost additional charges due to non-coverage. In these cases of non-coverage where you have received specific treatments, you the patient are responsible for the balance.

INITIAL_____

PATIENT RESPONSIBILITIES

Insurance: As a patient, it is your responsibility to notify the Front Desk Office if and when there are changes to your insurance (ie. Change of insurance carriers). Failure to do so causes the office to bill the wrong insurance company resulting in non-payment. In the event this happens you, the patient, are responsible for any outstanding/non-covered costs. *We may try to rebill the new insurance but there are certain time limits put in place where this may not be possible if the date of service is outside of the allottable period.*

INITIAL_____

Appointment Policy: Please give the office 24 hours notice if you need to cancel or reschedule your appointment. **Any appointment not cancelled within 24 hours will be assessed a missed appointment fee of $65.**

INITIAL_____

_____ _____

Patient Signature Date

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CENTRE FOR HEALTH AND WELLNESS

CONSENT TO DISCLOSE MEDICAL INFORMATION (OPTIONAL)

In compliance with HIPAA, the Khoury Centre is not authorized to provide information to other individuals without your explicit consent. If you wish to authorize KHOURY CHIROPRACTIC, INC. to share your medical information with individuals other than yourself, please complete this form with specifications of your wishes.

I authorize KHOURY CHIROPRACTIC, INC. and its staff to discuss my medical information including financial purposes, appointments, diagnosis and treatment information with the following exceptions:

_____

_____

_____

Below, please list the names and relationship of authorized individuals:

Name _____ Relationship _____

Name _____ Relationship _____

I understand that as part of KHOURY CHIROPRACTIC, INC. treatment, payment, or healthcare operations, it may be necessary to disclose my protected health information to another entity. I hereby consent to such disclosure for these permitted uses. I also hereby consent to such disclosures via fax.

_____ _____

Patient Name Printed Date

_____

Patient Signature

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KHOURY CHIROPRACTIC
CENTRE FOR HEALTH AND WELLNESS

WORKER'S COMPENSATION QUESTIONNAIRE

Please answer all questions completely

Dear Patient: This information is considered confidential. We need this information to determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. In order for us to understand your accident properly, please be as neat and accurate as possible while completing this form. Thank you.

Name_____
Company Name: _____ Employer's Name: _____
Phone: _____ Address: _____
Occupation: _____

Date and time present injury occurred: _____/_____/_____ at approximately _____AM/PM
Has this accident been reported to your employer? □ Yes □ No
When? _____ To Whom? _____

Please explain in detail how your accident happened:
_____
_____
_____
_____

Did you feel pain immediately after the accident? □ Yes □ No
If yes, where was this pain located? _____
If you were taken to the hospital, which one? _____
Have you lost time from work because of this accident? □ Yes □ No
If yes, when was your last day worked? _____
Are you being compensated for time lost from work? □ Yes □ No

Did you return to work? □ Yes □ No If yes, on what date did you return? _____

Did you consult any other doctor? □ Yes □ No
If yes, doctor's name_____ □ M.D. □ D.C. □ D.O. □ D.D.S.
Diagnosis, if any: _____

Did you receive any treatment? □ Yes □ No
If yes, please elaborate: _____

KHOURY CHIROPRACTIC
CENTRE FOR HEALTH AND WELLNESS

In your work, do you have to favor any part of your body? □ Yes □ No
If yes, please explain: _____

Do you have a history of absenteeism caused from accidents on the job? □ Yes □ No
Have you ever had a Workmen's Compensation claim before? □ Yes □ No
Before the injury were you capable of working on an equal basis with others of your age? □ Yes □ No
Are your work activities restricted because of this accident? □ Yes □ No
Since the injury occurred, are your symptoms: □ Improving □ Worsening □ No change

Have you retained an attorney? □ Yes □ No
If so, what is their name and address? _____

Have you ever injured this area before? □ Yes □ No If so, when? _____
If injured before, did you lose time from work? □ Yes □ No
If you lost time from work, give name of doctor or doctors consulted:
_____
_____

Do any other diseases or accidents affect your employment? □ Yes □ No
If yes, please explain:
_____
_____

Do you have any congenital factors or previous illness, which relate to this case? □ Yes □ No
If yes, please describe:
_____
_____

Have you ever been involved in a work accident before? □ Yes □ No
If yes, please describe: (include date and location of any injuries received)
_____
_____
_____
_____
_____

_____ _____
Patient's Signature Date

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CENTRE FOR HEALTH AND WELLNESS

WORKERS COMPENSATION INSURANCE INFORMATION

YOUR EMPLOYER'S INSURANCE INFORMATION

Name of Employer: _____

Employer's Insurance Company: _____

Address: _____ City: _____ State: _____ Zip: _____

Name of Medical Adjuster: _____

Phone Number: _____ Ext: _____ Fax: _____

CLAIM NUMBER: _____

Utilization Review Department Name: _____

Phone Number: _____ Fax: _____

PERSONAL HEALTH INSURANCE

Insurance Company: _____ Member ID: _____

Name of Insured Person: _____ Phone Number: _____

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CENTRE FOR HEALTH AND WELLNESS

If you have an attorney or plan to attain one, the next section MUST be completed in order to proceed with treatment.

IRREVOCABLE ASSIGNMENT OF BENEFITS FORM/LIEN

I hereby grant an irrevocable Equitable Lien and an *Official Legal Liens* as set forth in Ch111§70A through Ch111§70D Mass General Laws to said doctor against any and all proceeds of any settlement, judgment or verdict which may be paid as the result of the injuries for which I have been treated or injuries in connection therewith.

I hereby assign and authorize any and all medical benefits from any insurance plan or any other protection maintained by the patient and/or for the patient's behalf to which I am entitled, including but not limited to, Personal Injury Protection Benefits (PIP), optional medical payments benefits, disability insurance, bodily injury insurance, uninsured/underinsured insurance, worker's compensation, or any other private insurance or health plan be paid directly to:

KHOURY CHIROPRACTIC, INC.
640 Washington Street
Dedham, MA 02026
Tax ID: 04-3520390

For treatment resulting from an accident on _____ in _____ and rendered by Khoury Chiropractic Inc. and all medical staff associated with them.

I certify that the information given by me to Khoury Chiropractic Inc. in applying for payment under insurance plans or other protection is correct and complete.

I authorize all procedures related to my diagnoses, whether covered or not by my insurance plan, and I understand that I am financially responsible for all charges in excess of the plan's payment schedule and any charges incurred due to non-covered services.

I hereby authorize Khoury Chiropractic Inc. to release all information necessary including confidential medical records to any insurance company, adjuster, or attorney involved in collection of this matter in order to secure payment.

I hereby authorize Khoury Chiropractic Inc. to endorse/sign my name on and deposit any and all checks payable for their services. Should an insurance check be sent to me, I agree to forward it immediately to Khoury Chiropractic Inc.

I also understand that Khoury Chiropractic Inc. may file any appropriate complaint on my behalf.

A photocopy of this assignment is considered as effective and valid as the original for any successive services.

I understand this is an Irrevocable and Direct assignment of benefits.

_____ _____
Patient Signature Date

_____ _____
Witness Signature Date

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NOTICE OF IRREVOCABLE LIEN AND ASSIGMENT OF BENEFITS AUTHORIZATION

Patient name: _____ Patient address: _____

Date of Injury: _____ Insurance carrier: _____ Claim #: _____

Law office: _____ Attorney Name: _____

In consideration of the agreement of the provider named above to provide me with injury treatment services, I hereby to the extent of my treatment bills irrevocably assign to my provider 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 coverage; Medical Payment Coverage and health care coverage to which I may be entitled to pay my provider for services rendered to treat me on and after the above date.

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing him or her for professional services rendered me both by reason of this accident and by reason of any other bills that are due this office and to withhold such sums from any settlement, judgment or verdict as maybe necessary adequately to protect said doctor. I hereby further grant an irrevocable Equitable Lien and an Official Legal Liens as set forth in Ch111§70A through Ch111§70D Mass General Laws to said doctor against any and all proceeds of any settlement, judgment or verdict which may be paid to you, my attorney, or myself as the result of the injuries for which I have been treated or injuries in connection therewith.

I hereby authorize and direct any and all applicable insurance companies to make immediate payment directly to my said provider for all benefits and sums due me that may be due him or her upon receipt by you of my providers 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 fully understand that I am directly and fully responsible to said doctors for all professional bills submitted by him or her for service rendered me and that this agreement is made solely for said doctor's additional protection and in consideration of awaiting payment. I am aware that I remain personally responsible to my provider for the full amount of my unpaid treatment bills and I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

_____ _____

Patient Signature Date

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment verdict as may be necessary adequately to protect the said doctor named above.

_____ _____

Attorney Signature Date

Attorney: Please date, sign, and return one copy to doctor's office at once. Keep one copy for your records.