Informacion Confidencial Del Paciente

FECHA

¿CÓMO LLEGO A ESTA CLÍNICA? ¿QUIÉN LO/A REFIRIÓ A USTED? _____

¿ES SU VISITA POR MOTIVE DE UN ACCIDENTE? □SI□NO (SI MARCO SI, FAVOR DE COMPLETAR EL REPORTE DE HERIDA ACCIDENTAL)

INFORMACIÓN DEL PACIENTE

NOMBRE_____ TEL CASA _____ TEL TRABAJO_____

TEL CELULAR _____ CORREO ELECTRÓNICO _____

DIRECCIÓN _____ CIUDAD _____ ESTADO _____ CÓDIGO POSTAL _____

EDAD _____ FECHA DE NACIMIENTO _____ ESTADO MATRIMONIAL _____ NO. HIJOS _____

OCUPACIÓN _____ # DE LICENCIA _____ SS# _____

EMPLEADOR_____ DIRECCIÓN DE EMPLEO _____

NOMBRE DE ESPOSO/A _____ OCUPACIÓN _____ TEL TRABAJO _____

EMPLEADOR_ _____ DIRECCIÓN DE EMPLEO _____

NOMBRE DE CONTACTO DE EMERGENCIA _____ TEL _____

SÍNTOMAS

BREVEMENTE DESCRIBA SUS SÍNTOMAS _____

DOCTORES QUE HA VISITADO PARA TRATAR ESTA CONDICIÓN _____

HISTORIAL MÉDICO **(Si alguno es apropiado a su historial médico, favor de marcar el encasillado correspondiente.)**

□CANCER
□POLIO
□TUBERCULOSIS
□PRESIÓN ALTA
□PROBLEMAS DEL CORAZÓN
□DIABETES
□HEPATITIS
□SARAMPIÓN ALEMÁN
□ENFERMEDAD VENÉREA
□DISTROFIA MUSCULAR
□ESCLEROSIS MÚLTIPLE
□CONVULSIONES
□EPILEPSIA
□CONCUSIÓN-GOLPE
□MAREOS
□ARTRITIS
□ENTUMECIMIENTO
□REUMATISMO
□FIEBRE REUMÁTICA
□FIEBRE ESCARLATINA
□NERVIOS
□ASMA
□DESORDEN ESTOMACAL
□SINUSITIS
□DOLOR DE ESPALDA
□ADORMECIMIENTO
□ANEMIA

DESCRIBA LAS OPERACIONES QUE HA TENIDO _____ ¿CUANDO? _____

¿HA SIDO TRATADO POR ALGÚN MEDICO DE ALGUNA ENFERMEDAD EN EL AÑO PASADO?□SI □NO

DESCRIBA LA ENFERMEDAD _____ FECHA DEL ÚLTIMO EXAMEN FÍSICO _____

¿ES USTED ALÉRGICO/A A ALGÚN MEDICAMENTO?□SI□NO ¿QUÉ CLASE? _____

¿ESTÁ USANDO ALGÚN MEDICAMENTO? □SI□NO ¿QUÉ CLASE? _____

SI ES MUJER, ¿ESTÁ EMBARAZADA? □SI □NO ¿FECHA DE ULTIMA MENSTRUACIÓN? _____

INFORMACIÓN DEL SEGURO **(Es requisito de la clínica que la primera visita se formule arreglo para el pago.)**

NOMBRE DE LA PERSONA RESPONSABLE DEL PAGO _____ TEL(_____)_____

¿TIENE SEGURO? □SI□NO NOMBRE DE COMPAÑÍA _____

FAVOR DETALLAR TODAS LAS CUBIERTAS DE SEGURO

SEGURO DEL PACIENTE _____ SEGURO DE ESPOSO/A _____

SEGURO COMPENSACIÓN DE ACCIDENTE DEL TRABAJO_____ NUMERO DE RECLAMO, SI ABIERTO _____

OTROS SEGUROS _____

Estoy de acuerdo u entiendo que las pólizas de seguro y accidente son un arreglo entre la Compañíay yo. Entiendo además que esta oficina preparara las formas y documentos necesarios para ayudarme a recobrar de la Compañia de Seguro cualquier cantidad autorizada a pagar directamente a esta oficina será acreditada a mi cuenta al recibo de la misma. Autorizo y permito a esta oficina a endorsar remesas pagaderas a ambos para ser acreditada a mi cuenta. No obstante, entiendo y acepto que todos los servicios preciados a mi serán cargados a mi y soy responsable del pago.Además entiendo que si suspendo o termino el tratamiento, cualquiera factura por servicios profesionales rendidos a mi vencerá y deberá ser pagada al instante.

FIRMA DE PACIENTE _____ FECHA _____

FIRMA DE ESPOSO/A O TUTOR _____ FECHA _____

Si lo de usted es dado a una herida accidental, favor de completar el Reporte De Herida Accidental también.

REPORTE DE HERIDA ACCIDENTAL

NOMBRE: _____

TYPO DE ACCIDENTE: ☐ DE TRABAJO ☐ DE TRAFICO ☐ OTRO: _____ FECHA: _____

FECHA DEL ACCIDENTE: _____ LA HORA: _____ AM PM LOCAL DEL ACCIDENTE: _____

SI EL ACCIDENTE FUE RELACIONADO CON SU TRABAJO, COMPLETE ESTA SECCIÓN:

PATRON: _____ TIPO DE NEGOSIO: _____

¿FUE EL ACCIDENTE REPORTADO A SU SUPERVISOR O PATRÓN? SI NO ¿QUIEN? _____

¿FUE RECLAMADO A LA RECOMPENSA DE TRABAJADORES? SI NO

SI EL ACCIDENTE FUE UN ACCIDENTE DE TRÁFICO, COMPLETE ESTA SECCIÓN:

¿QUE TIPO DE VEHÍCULO FUE ENVUELTO EN EL ACCIDENTE? ☐ AUTO ☐ CAMIONETA ☐ MOTOCICLETA ☐ OTRO

USTED FUE EL: ☐ CHOFER ☐ PASAJERO ☐ PEATON

¿ESTABA SU VEHÍCULO EN MOVIMIENTO CUANDO OCURRIO EL ACCIDENTE? SI NO SI INDICO SI, MPH: _____

¿PEGO SU VEHÍCULO A OTROS VEHÍCULOS? SI NO ¿DONDE? _____

¿PEGARON OTROS VEHÍCULOS A SU VEHÍCULO? SI NO ¿DONDE? _____

¿FUE EL ACCIDENTE REPORTADO AL DEPARTAMENTO DE POLICIA? SI NO NÚMERO DE CASO/RECLAMO: _____

¿FUERON PUBLICADAS CITACIONES DE TRÁFICO? SI NO ¿A QUIÉN? _____

DESCRIBA EL ACCIDENTE, LA CAUSA Y LAS CIRCUNSTANCIAS DEL ALREDEDOR:

_____

_____

_____

QUEJAS PRESENTES- INDIQUE TODO LO QUE APLIQUE:

☐ DOLORES DE CABEZA
☐ PARECE PESADA SU CABEZA
☐ CABEZA Y HOMBROS CANSADOS Y PESADOS
☐ EMBOTAMIENTOS (DE LOS SENTIDOS O INTELIGENCIA)
☐ FALTA DE MEMORIA
☐ PROBLEMAS DE EQUILIBRIO
☐ MAREOS
☐ DESMAYOS
☐ TEMBLORES
☐ PALPITACIÓNES
☐ DOLOR DE CUELLO
☐ CUELLO TIESO
☐ RESTRICCIÓN EN MOVIMIENTO DEL CUELLO
☐ ESPALDA DE ARRIBA ADOLORIDA/TIESA
☐ MEDIA ESPALDA ADOLORIDA/TIESA
☐ CINTURA ADOLORIDA/TIESA

☐ PIQUETES EN LOS BRAZOS/LAS PIERNAS
☐ ENTUMECIDO LOS DEDOS/BRAZOS/PIERNAS
☐ DOLOR DE PECHO
☐ PROBLEMAS DE RESPIRO
☐ TENSIÓN DE LOS OJOS
☐ DOLOR DETRÁS DE LOS OJOS
☐ OJOS SENSITIVOS A LA LUZ
☐ PROBLEMA EN ENFOCAR LA VISTA
☐ VISIÓN DOBLE
☐ SONIDOS EN LOS OÍDOS
☐ PERDIDA DE SABOREAR
☐ PERDIDA DEL OLFATO
☐ SINUSITIS
☐ NERVOSIDAD
☐ TENSIÓN
☐ IRRITABLE

☐ ANSIEDAD
☐ EXTREMADAMENTE FATIGADO/A
☐ INSOMNIO
☐ NEURITIS
☐ CALENTURAS
☐ PÁLIDO/A
☐ SUDA DEMASIADO
☐ PROBLEMAS DE DIGESTION
☐ NAUSEA/VÓMITOS
☐ DIARREA
☐ ESTREÑIMIENTO
☐ DEPRIMIDO/A
☐ HINCHADO/A _____
☐ PIES/MANOS FRÍOS
☐ DIFICULTAD CON TIEMPO PROLONGADO EN AUTO

☐ DIFICULTAD EN DEMACIADO TIEMPO ☐ PARADO/A ☐ ANDANDO ☐ ANDANDO EN BICICLETA ☐ DOBLÁNDOSE / AGACHÁNDOSE
☐ DOLOR O TIESO AL LEVANTARSE EN EL CUELLO/LA CINTURA
☐ CORRE EL DOLOR PARA: ☐ CUELLO ☐ BASE DEL CRÁNEO ☐ HOMBROS ☐ CADERA
☐ BRAZO DERECHO ☐ BRAZO IZQUIERDO ☐ LOS DOS ☐ PIERNA DERECHA ☐ PIERNA IZQUIERDA ☐ LAS DOS

¿REQUIRIÓ USTED TRATAMIENTO EN ALGÚN HOSPITAL? SI NO ¿EN CUAL HOSPITAL? _____

¿HA TENIDO USTED ALGÚN ACCIDENTE O ALGUNA LASTIMADURA COMO ESTA ANTES? SI NO

SÍNTOMAS APARTE DE LOS QUE FUERON MENCIONADOS _____

¿HA FALTADO AL TRABAJO DADO A ESTA LASTIMADURA? SI ES UN SÍ, ¿CUÁNDO? _____

COMPAÑÍAS DE SEGURO INVOLUCRADAS

COMPAÑÍA DE SEGURO DE LA PERSONA RESPONSABLE POR LOS PAGOS _____ # DE RECLAMO _____

¿HA TENIDO CONTACTO CON USTED ALGÚN AJUSTADOR O REPRESENTANTE DEL SEGURO TRATÁNDOSE DE ESTE RECLAMO? SI NO

¿LE HA ACONSEJADO SU ABOGADO EN ESTE CASO? SI NO

NOMBRE, DOMICILIO & # DE TELÉFONO DE SU ABOGADO _____

FIRMA DEL PACIENTE: _____ **FECHA:** _____

Gilroy Chiropractic Center
7888 Wren Ave, Ste B-123
Gilroy, CA 95020
(408)848-3666

HIPPA Privacy Practices Consent

Name of Patient: _____

Date of Birth: _____

I acknowledge that I have read and understand the Gilroy Chiropractic Center HIPPA Notice of Privacy Practices and have received a written copy if requested. If I am not the patient, I represent that I am authorized by law to act on the patient's behalf.

_____ _____
Signature **Date**

If not signed by patient, indicate authority to act for patient: _____

FOR OFFICE USE ONLY

COMPLETE IF NO ACKNOWLEDGEMENT CAN BE OBTAINED

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained from the patient or patient's authorized representative because:

_____ Individual refused to sign
_____ Other (please describe) _____

_____ _____
Signature Date

Gilroy Health & Wellness Center
Robert W. Kovacs, D.C.
7888 Wren Ave Ste. B-123
Gilroy, CA 95020

Informed Consent Document

To the Patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment.

The primary treatment used by doctors of chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

The risks inherent in chiropractic adjustment.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include, but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. The Chiropractor will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to the Chiropractor's attention, it is your responsibility to inform the Chiropractor.

CONSENT TO TREATMENT (MINOR)

I hereby request and authorize Robert Kovacs, DC, to perform diagnostic tests and render chiropractic adjustments and other treatment to my minor son/daughter: _____. This authorization also extends to all other chiropractors and/or office staff members and is intended to include radiographic examination at the chiropractor's discretion.

As of this date, I have the legal right to select and authorize health care services for the minor child named above. (If applicable) Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I herby give my consent to that treatment.

Dated: _____

_____ _____

Patient's Name **Patient's Signature**

_____ _____

Parent or Guardian's Name (if a minor) **Signature of Parent or Guardian (if a minor)**

GILROY CHIROPRACTIC CENTER

Dr. Robert W. Kovacs

PERSONAL INJURY POLICY

I understand that I am being treated for injuries sustained in a personal injury/motor vehicle accident. Because of the laws governing treatment in cases such as mine, the treatment plan, which has been recommended in my case, must be strictly adhered to. I understand that failure to present for care as recommended may lead to dismissal from treatment and may jeopardize future treatment and/or benefits, such as an insurance carrier's responsibility for medical costs and/or compensation.

I further understand that I will be treated until I have reached a level of maximum medical improvement, at which time I will be released from treatment as a result of the injuries sustained in the accident. This is not meant to imply that I will not need further treatment but only that the injuries sustained in the accident have reached maximum medical improvement.

NAME: _____

DATE: _____

WITNESS: _____

POWER OF ATTORNEY TO ENDORSE CHECKS

KNOW ALL MEN BY THESE PRESENT: That the undersigned has made, constituted and appointed, and by these presents does hereby make, constitute and appoint the Gilroy Chiropractic Center clinic and any of its duly authorized agents and employees as and to be the undersigned's true and lawful Attorney In Fact for and in the undersigned's name, place and stead to **endorse any and all checks, drafts or money orders which are made payable to the undersigned alone or to the undersigned and the said** Gilroy Chiropractic Center clinic which checks, drafts or money orders are to **pay for Chiropractic services** or the like which have been made by Gilroy Chiropractic Center clinic at the request or with the knowledge and approval of the undersigned and/or the maker of the check, draft or money order.

The undersigned by these present does thus give and grant unto the said Gilroy Chiropractic Center clinic the full power and authority to do and preform all and every act and thing whatsoever requisite and necessary to be done in and about the premises as fully to all intents and purposes as the undersigned might or could do to personally present insofar as the **endorsing** and **cashing** of said checks are concerned.

The undersigned does hereby ratify and confirm any and all actions taken by Gilroy Chiropractic Center clinic as Attorney In Fact, in accordance with this special power of attorney and shall do or cause to be done by virture of these presents.

IN WITNESS WHEREOF the undersigned have hereunto set their hands, this _____ day of _____, 20 _____

_____
Witness to Patient's Signature

_____
Patient's Full Name (Typed)

_____
Signature of Patient

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? PLACE (State) YES NO

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1									NPI	
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

Gilroy Chiropractic Center
7888 Wren Ave. Ste B-123
Gilroy, CA 95020
408-848-3666

PI Payment Assignment Form

Date:

_____
_____
_____

Patient Name: _____

CLAIM#: _____

POLICY#: _____

To Whom It May Concern:

Please make all medical payments directly to:
Dr. Robert Kovacs of Gilroy Chiropractic Center (Tax ID# 770104716)
7888 Wren Ave B123
Gilroy, CA 95020

Thank you,

_____
Patient Signature

NOTICE OF DOCTOR'S LIEN

Patient: _____

Date of Accident: _____

I do hereby authorize Robert W. Kovacs, D.C. to furnish you, my attorney, with a full report of his examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was recently involved.

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing him for medical service rendered me both by reason of this accident and by reason of any other bills that are due his office and withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect and fully compensate said doctor. And I hereby further give a Lien on my case to said doctor against any and all proceeds of my 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 fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for service rendered me and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

I agree to promptly notify said doctor of any change or addition of attorney(s) used by me in connection with this accident, and I instruct my attorney to do the same and to promptly deliver a copy of this lien to any such substituted or added attorney(s).

Please acknowledge this letter by signing below and returning to the doctor's office. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment but may declare the entire balance due and payable.

Dated _____ _____

Patient's Signature

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 or verdict, as may be necessary to adequately protect and fully compensate said doctor above-named. Attorney further agrees that in the event this Lien is litigated that the prevailing party will be awarded attorney fees and costs.

Dated _____ _____

Attorney's Signature

Please date, sign and return one copy to doctor's office. Also keep one copy for your records.

Doctor: Robert W. Kovacs, D.C.
Address: 7888 Wren Ave, Suite B123
Gilroy, CA 95020

NOTICE OF DOCTOR'S LIEN

Patient: _____

Date of Accident: _____

I do hereby authorize Robert W. Kovacs, D.C. to furnish you, my attorney, with a full report of his examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was recently involved.

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing him for medical service rendered me both by reason of this accident and by reason of any other bills that are due his office and withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect and fully compensate said doctor. And I hereby further give a Lien on my case to said doctor against any and all proceeds of my 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 fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for service rendered me and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

I agree to promptly notify said doctor of any change or addition of attorney(s) used by me in connection with this accident, and I instruct my attorney to do the same and to promptly deliver a copy of this lien to any such substituted or added attorney(s).

Please acknowledge this letter by signing below and returning to the doctor's office. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment but may declare the entire balance due and payable.

Dated _____ _____

Patient's Signature

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 or verdict, as may be necessary to adequately protect and fully compensate said doctor above-named. Attorney further agrees that in the event this Lien is litigated that the prevailing party will be awarded attorney fees and costs.

Dated _____ _____

Attorney's Signature

Please date, sign and return one copy to doctor's office. Also keep one copy for your records.

Doctor: Robert W. Kovacs, D.C.
Address: 7888 Wren Ave, Suite B123
Gilroy, CA 95020

NOTICE OF DOCTOR'S LIEN

Patient: _____

Date of Accident: _____

I do hereby authorize Robert W. Kovacs, D.C. to furnish you, my attorney, with a full report of his examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was recently involved.

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing him for medical service rendered me both by reason of this accident and by reason of any other bills that are due his office and withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect and fully compensate said doctor. And I hereby further give a Lien on my case to said doctor against any and all proceeds of my 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 fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for service rendered me and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

I agree to promptly notify said doctor of any change or addition of attorney(s) used by me in connection with this accident, and I instruct my attorney to do the same and to promptly deliver a copy of this lien to any such substituted or added attorney(s).

Please acknowledge this letter by signing below and returning to the doctor's office. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment but may declare the entire balance due and payable.

Dated _____ _____

Patient's Signature

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 or verdict, as may be necessary to adequately protect and fully compensate said doctor above-named. Attorney further agrees that in the event this Lien is litigated that the prevailing party will be awarded attorney fees and costs.

Dated _____ _____

Attorney's Signature

Please date, sign and return one copy to doctor's office. Also keep one copy for your records.

Doctor: Robert W. Kovacs, D.C.
Address: 7888 Wren Ave, Suite B123
Gilroy, CA 95020

NOTICE OF DOCTOR'S LIEN

Patient: _____

Date of Accident: _____

I do hereby authorize Robert W. Kovacs, D.C. to furnish you, my attorney, with a full report of his examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was recently involved.

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing him for medical service rendered me both by reason of this accident and by reason of any other bills that are due his office and withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect and fully compensate said doctor. And I hereby further give a Lien on my case to said doctor against any and all proceeds of my 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 fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for service rendered me and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

I agree to promptly notify said doctor of any change or addition of attorney(s) used by me in connection with this accident, and I instruct my attorney to do the same and to promptly deliver a copy of this lien to any such substituted or added attorney(s).

Please acknowledge this letter by signing below and returning to the doctor's office. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment but may declare the entire balance due and payable.

Dated _____ _____

Patient's Signature

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 or verdict, as may be necessary to adequately protect and fully compensate said doctor above-named. Attorney further agrees that in the event this Lien is litigated that the prevailing party will be awarded attorney fees and costs.

Dated _____ _____

Attorney's Signature

Please date, sign and return one copy to doctor's office. Also keep one copy for your records.

Doctor: Robert W. Kovacs, D.C.
Address: 7888 Wren Ave, Suite B123
Gilroy, CA 95020