Johnson Chiropractic & Holistic Health Center, LLC.
Chiropractic – Acupuncture – Nutrition & Functional Medicine – Injury Rehab

Dr. Kody R. Johnson, DC, MTAA

FILE #: _____

Clinic Use: INS: _____ DOI: _____

Patient Information (please print):

Full Name (First, MI, Last): _____ Birth Date: _____ Sex: M / F

SS# (for identification & insurance purposes): _____ Home Phone: _____

Address: _____ Cell Phone: _____

City: _____ State: ____ Zip: _____ Work Phone: _____

Email: _____ Occupation: _____

Emergency Contact: _____ Employer: _____

Emergency Contact Phone #: _____ How did you hear about us? _____

Injuries & Symptoms (please print):

- Were you unconscious immediately after the accident? □ No □ Yes - for how long? _____
- Please describe how you felt immediately after the accident: _____

_____

_____

- Have you been able to work since the accident? □ No □ Yes If NO, how many work days have you missed? _____
- Prior to the accident / injury were you able to work on an equal basis with others your age? □ No □ Yes
- Have you had any of the following symptoms since your accident:

□ Arm/Shoulder Pain	□ Chest Pain	□ Feet/Toe Numbness	□ Leg pain	□ Shortness of Breath
□ Back Pain	□ Dizziness	□ Hand/Finger Numbness	□ Memory Loss	□ Sleep Difficulty
□ Back Stiffness	□ Ear Buzzing	□ Headaches	□ Nausea	□ Stomach Upset
□ Blurred Vision	□ Ear Ringing	□ Irritability	□ Neck Pain	□ Tension
□ Bowel/Bladder Problems	□ Fatigue	□ Jaw Problems	□ Neck Stiffness	□ Urinary Problems

- Are these conditions getting progressively worse? □ Yes □ No □ Unknown
- How often are your symptoms present?
  □ 0 - 25% □ 26 - 50% □ 51 - 75% □ 76 - 100%
- What is your average pain level for the past week?
  0 ----------5----------10
  No Pain Unbearable
- Does it interfere with: □ Work □ Sleep □ Daily Routine □ Recreation
- What aggravates / increases your symptoms? _____

_____

_____

- What helps / relieves your symptoms? _____

_____

_____

- What have you been unable to do because of these symptoms? _____

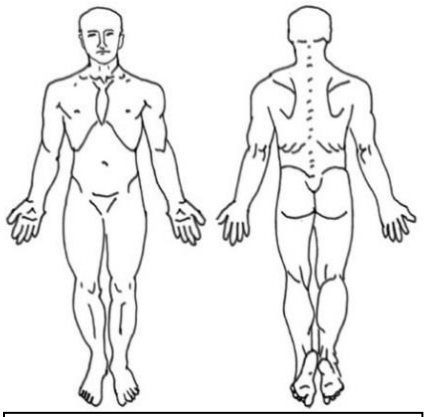
_____

_____

- Is there anything else we should know regarding your conditions / symptoms?

_____

_____



Mark your current symptoms on the diagram above:

A = Aching **B** = Burning
N = Numbness **P** = Pins & Needles
S = Stabbing **O** = Other: Describe:

_____

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Accident Site, Vehicle Information & Impact (please print):

- Was the impact from: □ Front □ Rear □ Left □ Right □ Other: _____
- Were you: □ Surprised by impact □ Braced for impact
- Did any part of your body strike anything in the vehicle? □ No □ Yes - explain: _____
- At the time of the impact were you:
  □ Looking straight ahead □ Looking back
  □ Looking to the left □ Looking to the right
  □ Looking up □ Looking down

- Date & Time of Accident: _____
- Driving Conditions: □ Dry □ Wet □ Icy □ Snow □ Gravel □ Muddy □ Fog □ Other: _____
- Road/Street Name: _____
- City/State: _____
- Direction Heading: _____
- Speed Traveling: _____

- Year, Make & Model of Vehicle You Were In: _____
- Were you the: □ Driver □ Front Passenger □ Rear Passenger □ Pedestrian
- Were you wearing a Seat Belt? □ No □ Yes
  If Yes, was it a: □ Lap Belt Only □ Shoulder Belt
- Did your seat have a headrest? □ Yes □ No
- Did the airbags deploy? □ Yes □ No

- In your own words, describe the accident: _____

- Make & Model of other vehicle: _____
- What direction were they heading? _____
- What speed were they traveling? _____
- Did the police come to the accident site? □ No □ Yes
- Was a report filed? □ No □ Yes
  (Please provide a copy of the police report if available)

Treatment (please print):

- Did you go to the hospital? □ No □ Yes - How did you get to the hospital? □ Ambulance □ Private transportation
- When did you go? □ Immediately after / Same day □ Next day □ 2 or more days after
- Name of hospital: _____ • Name of doctor: _____
- Diagnosis: _____
- Initial treatment received: _____
- Were X-Rays or MRI's taken? □ No □ Yes - please provide copies of x-rays
- What other treatment have you received? _____

Leave Blank - Doctors Notes:

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Treatment Continued (please print)**:**

• Please list Medications & Supplements you are currently taking, or have taken within the last three (3) months. Include prescription and over the counter. Attach a list if necessary.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

• Please list ALL SURGERIES, on all areas of your body and the date(s) performed. These do not have to pertain to the accident. Attach list if necessary:

Surgery #1: _____
Date Performed: _____

Surgery #2: _____
Date Performed: _____

Surgery #3: _____
Date Performed: _____

Surgery #4: _____
Date Performed: _____

Surgery #5: _____
Date Performed: _____

Auto Insurance Information & Attorney Information (please print)**:**

• Your Auto Insurance Co: _____ • Claim #: _____

• Agent's Name: _____ • Phone: _____

• Address: _____ • Fax: _____

_____ • Email: _____

• Have you retained an attorney at this time? □ No □ Yes - Attorney's Name: _____

• Attorney's Firm: _____ • Phone: _____

• Address: _____ • Fax: _____

_____ • Email: _____

• Other Party Auto Insurance Co: _____ • Claim #: _____

• Adjuster's Name: _____ • Phone / Fax: _____

• Address: _____ • Email: _____

Leave Blank – Doctor Use Only:

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PATIENT TREATMENT AGREEMENT FORM &
CLINIC PAYMENT POLICY – OUT-OF-POCKET PAYMENT & INSURANCE PROCESSING POLICY

INFORMED CONSENT:

- DEPENDING UPON YOUR CONDITION, YOU WILL REQUIRE A UNIQUE AMOUNT AND TYPE OF CARE DESIGNED SPECIFICALLY FOR YOUR CONDITION. AS WITH ALL HEALTHCARE TYPES, FOLLOWING THE PRESCRIBED TREATMENT PLAN AS RECOMMENDED BY THE DOCTOR OF CHIROPRACTIC DOES NOT CONSTITUTE NOR GUARANTEE A CURE.
- CHIROPRACTIC IS A CONSERVATIVE AND LOW RISK HEALTH CARE CHOICE. MOST COMMON SIDE-EFFECTS CAN INCLUDE SOME MINOR SORENESS, SIMILAR TO THAT WHICH IS FELT FROM EXERCISING. A VERY RARE SIDE-EFFECT IS VERTEBROBASILAR INCIDENT (VBI) OR STROKE FROM CERVICAL ADJUSTMENT. THE RISK IS REPORTED IN THE SCIENTIFIC LITERATURE AS BEING *1:1 MILLION TO 1:4 MILLION* ADJUSTMENTS. THE LIKELIHOOD OF THIS OCCURRING IS JUST AS COMMON AS IF YOU WERE TO GET YOUR HAIR WASHED AT A HAIR-SALON, OR IF YOU TURN YOUR HEAD TO LOOK BACK AS YOU BACK OUT OF YOUR DRIVEWAY. RECENT RESEARCH SHOWS THAT A VISIT TO A CHIROPRACTOR'S (D.C.) OFFICE IS JUST AS SAFE AS A VISIT TO AN M.D.'S OFFICE IN THIS REGARD. FURTHERMORE, IT HAS BEEN DECIDED THAT TREATMENT DOES NOT CAUSE VBI, RATHER, PATIENTS REPORT TO EITHER AN M.D. OR D.C. FOR SYMPTOMS OF A VBI WITHOUT KNOWING THEY ARE HAVING THIS SYNDROME IN THE FIRST PLACE SINCE IT MIMICS THE SYMPTOMS OF MIGRAINE HEADACHE OR NECK PAIN. OTHER POSSIBLE RARE COMPLICATIONS FROM CARE INCLUDE FRACTURE, OR SPRAIN / STRAIN OF THE AFFECTED BODY REGIONS.
- OTHER COMMON METHODS OF TREATING NEUROMUSCULOSKELETAL PROBLEMS SUCH AS TAKING TYLENOL, IBUPROFEN, ASPIRIN, AND NAPROXEN HAVE A SIGNIFICANTLY HIGHER RISK OF AN ADVERSE EVENT AS COMPARED TO CHIROPRACTIC CARE (*3200:1MILLION VS. 1:1MILLION*). SPINAL SURGERY ALSO POSSESSES A SIGNIFICANTLY HIGHER RISK AS COMPARED TO CHIROPRACTIC AS WELL (*15,600:1 MILLION VS. 1:1 MILLION*).
- BY SIGNING THIS FORM, YOU ARE AWARE OF AND ARE TAKING RESPONSIBILITY FOR ANY RISKS OR BENEFITS, AND ARE STATING THAT YOU WOULD LIKE TO BEGIN CARE HERE AT OUR CLINIC.

CONSENT TO PRIVACY PRACTICES:

- YOUR HEALTH INFORMATION IS CONSIDERED TO BE PROTECTED AND CONFIDENTIAL. UNDER FEDERAL LAW (HIPAA), OUR CLINIC MUST KEEP YOUR PROTECTED HEALTH INFORMATION (PHI) CONFIDENTIAL AND CAN ONLY USE IT WITHIN CERTAIN GUIDELINES, WHICH MAY BE SUBJECT TO YOUR PRIOR APPROVAL. OUR CLINIC WILL USE YOUR PHI IN ORDER TO FORMULATE AN APPROPRIATE DIAGNOSIS AND TREATMENT PLAN, MAKE ANY NECESSARY REFERRALS; COLLECT PAYMENT FROM YOUR INSURANCE COMPANY, ATTORNEY, YOURSELF, OR ANY OTHER NECESSARY COLLECTIONS AGENCY, OR INDIVIDUAL. OF COURSE, YOU MAY LIMIT HOW WE USE AND TO WHOM WE DISCLOSE YOUR PHI TO. YOU MUST PUT ANY EXCEPTIONS IN WRITING AND GIVE TO OUR FRONT DESK STAFF. BY SIGNING THIS FORM YOU ARE AGREEING TO OUR PRIVACY PRACTICES. YOU ARE ALSO GIVING OUR OFFICE THE ABILITY TO CONTACT YOU BY ANY MEANS NECESSARY, INCLUDING BUT NOT LIMITED TO: MAIL, EMAIL, TELEPHONE, FAX, ETC. IF YOU WOULD LIKE A COPY OF OUR CLINIC'S "PRIVACY PRACTICES POLICY", PLEASE ASK ANY OF OUR STAFF AND THEY WILL PROVIDE YOU WITH ONE.

SCHEDULING, ATTENDANCE & PAYMENT POLICY:

- ANY APPOINTMENT YOU MAKE IS RESERVED SPECIFICALLY FOR YOU. ARRIVING MORE THAN **FIVE** MINUTES LATE TO AN APPOINTMENT WILL RESULT IN YOUR APPOINTMENT BEING TREATED AS A "WALK-IN", AND YOU WILL BE SEEN AT THE NEXT AVAILABLE TIME.
- IF YOU WILL BE UNABLE TO BEEN SEEN AT YOUR SCHEDULED APPOINTMENT TIME, YOU ARE REQUIRED TO CALL AND INFORM OUR CLINIC AT LEAST **FOUR** HOURS BEFORE YOUR SCHEDULED APPOINTMENT TIME TO CANCEL OR RESCHEDULE. FAILURE TO DO SO WILL RESULT IN A NO-CALL-NO-SHOW, AND WE RESERVE THE RIGHT TO CHARGE YOU THE FEE EXPECTED AT TIME OF SERVICE.
- PAYMENT IS EXPECTED IN FULL AT THE TIME OF SERVICE. FEES ARE NOT NEGOTIABLE. ACCOUNTS THAT ARE DUE PAST 30 DAYS WILL INCUR A $10 LATE FEE AFTER EACH 30 DAYS. AFTER 90 DAYS, THE AMOUNT WILL BE TURNED INTO COLLECTIONS. ACCOUNTS IN THE COLLECTIONS PROCESS WILL ACCRUE 15% INTEREST PER ANNUM UNTIL COLLECTED FULLY. THE PATIENT IS ALSO RESPONSIBLE TO PAY COURT COSTS, ATTORNEY FEES, AND ANY OTHER FEE ASSOCIATED WITH THE COLLECTIONS PROCESS IN ADDITION TO THE FEES OF THEIR DELINQUENT ACCOUNT. IF YOUR HEALTH INSURANCE, CAR INSURANCE, PERSONAL INJURY SETTLEMENT, WORKER'S COMPENSATION INSURANCE, PAYMENT OR SETTLEMENT AMOUNT, ATTORNEY, OR ANY OTHER PAYING ENTITY FAILS TO PAY OUR CLINIC COMPLETELY FOR SERVICES RENDERED, YOU ARE STILL RESPONSIBLE TO PAY ALL OF THE DIFFERENCE DUE. WE HAVE NO CONTROL OVER WHAT YOUR INSURANCE COMPANY OR OTHER PAYING ENTITY WILL OR WILL NOT PAY, AND OUR CLINIC WILL NOT BE HELD RESPONSIBLE AS SUCH. YOUR SIGNATURE INDICATES YOUR AGREEMENT WITH THESE POLICIES AND CLAUSES.

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PATIENT TREATMENT AGREEMENT FORM &
CLINIC PAYMENT POLICY – OUT-OF-POCKET PAYMENT & INSURANCE PROCESSING POLICY (CONTINUED)

- PAYMENT IS REQUIRED FOR YOUR AMOUNT OWED AT TIME OF SERVICE.

- OUR CLINIC WILL GLADLY SUBMIT INSURANCE CLAIMS ON YOUR BEHALF FOR SERVICES RENDERED. HOWEVER, *IN THE EVENT YOUR HEALTH INSURANCE OR OTHER PAYING ENTITY DOES NOT COVER OUR SERVICES, YOU (THE PATIENT) WILL BE REQUIRED TO PAY, IN FULL, ANY AMOUNT NOT COVERED. IT IS YOUR RESPONSIBILITY TO KNOW YOUR OWN INSURANCE BENEFITS, AND OUR CLINIC DOES NOT ASSUME RESPONSIBILITY IN THE EVENT WE ARE GIVEN INCORRECT INSURANCE BENEFIT QUOTES* FROM AN INSURANCE COMPANY. THE ACT OF OUR OFFICE LOOKING UP HEALTH INSURANCE BENEFITS IS A COURTESY TO YOU, OUR PATIENT, BUT IS NOT A REQUIREMENT.

- IF YOU (THE PATIENT) ARE MEETING YOUR DEDUCTIBLE ON YOUR INSURANCE PLAN, YOU WILL BE ASKED TO PAY THE FULL AMOUNT OF YOUR VISIT AT THE TIME OF SERVICE. IF WE ARE EVER IN DOUBT OF THE DEGREE OF INSURANCE COVERAGE PRESENT, YOU (THE PATIENT) WILL BE REQUIRED TO PAY THE FULL AMOUNT DUE ON THE SAME DATE OF SERVICE.

- IF YOUR INSURANCE CLAIM IS DENIED, YOU WILL BE ASKED TO PAY THE OUTSTANDING BALANCE ON YOUR ACCOUNT. IF YOU BELIEVE THE SERVICES SHOULD HAVE BEEN APPROVED AND PAID FOR BY YOUR INSURANCE YOU MAY REQUEST THAT WE RESUBMIT YOUR CLAIM(S). IF CLAIMS ARE RESUBMITTED AND APPROVED BY YOUR INSURANCE YOU WILL BE REIMBURSED OR CREDITED BACK FUNDS, IF AND WHEN THOSE DATE(S) OF SERVICE ARE PAID FOR BY YOUR INSURANCE.

- IN NO INSTANCE SHALL OUR CLINIC EVER BE REQUIRED TO RESUBMIT A PREVIOUSLY DENIED CLAIM IF WE EXPECT THE RESUBMITTED CLAIM WILL ALSO BE DENIED.

- WE ARE IN-NETWORK AND / OR ARE PARTICIPATING PROVIDERS WITH MOST, BUT NOT ALL INSURANCE PLANS. BEING AN IN-NETWORK / PARTICIPATING PROVIDER MEANS THAT WE WILL ACCEPT THE CONTRACTED AMOUNT ON CONTRACTED COVERED SERVICES AS PAYMENT IN FULL IN ADDITION TO ANY REQUIRED COPAYS / COINSURANCE PAYMENTS. HOWEVER, IN THE EVENT A SERVICE IS NOT COVERED OR IS NOT A CONTRACTED SERVICE, YOU (THE PATIENT) ARE OBLIGATED TO PAY OUR CLINIC IN FULL FOR SERVICES RENDERED AT OUR CLINIC'S TYPICAL FEE SCHEDULE. IF INSURANCE IS BILLED AND DOES NOT PAY FOR SERVICES RENDERED, YOU (THE PATIENT) WILL BE REQUIRED TO PAY THE AMOUNT OUTSTANDING THAT WAS BILLED TO INSURANCE.

- FOR PATIENTS WITH **MEDICARE** COVERAGE, ONLY EIGHTY PERCENT (80%) OF MEDICALLY NECESSARY CHIROPRACTIC SPINAL ADJUSTMENTS ARE REIMBURSED *AFTER MEETING YOUR MEDICARE DEDUCTIBLE*. ALL OTHER CLINIC SERVICES MUST BE PAID FOR OUT OF POCKET. IF YOU ARE A MEDICARE PATIENT WITH A SECONDARY INSURANCE, THERE IS NO GUARANTEE THE SECONDARY INSURANCE WILL COVER THESE OTHER SERVICES; IF NONPAYMENT BY THE INSURANCE COMPANY(S) SHOULD OCCUR IT IS YOUR (THE PATIENT'S) RESPONSIBILITY FOR THE REMAINING AMOUNT. IF MEDICARE DOES NOT FORWARD A CLAIM TO YOUR SECONDARY, IT IS YOUR (THE PATIENT'S) RESPONSIBILITY TO CONTACT MEDICARE TO ENSURE THAT THE CLAIM IS FORWARDED.

BY SIGNING BELOW, I AM ACKNOWLEDGING THAT I HAVE READ, UNDERSTAND, AND AGREE WITH ALL THE STATEMENTS, POLICIES, AND PROCEDURES LISTED ABOVE.

PATIENT NAME PRINTED: _____ DATE: _____

PATIENT SIGNATURE: _____

IF SINGING FOR A MINOR

GUARDIAN NAME & RELATIONSHIP PRINTED: _____

GUARDIAN SIGNATURE: _____ DATE: _____

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ASSIGNMENT OF PROCEEDS, CONTRACTUAL, LIEN, AND AUTHORIZATION
("Agreement")

I HEREBY AUTHORIZE AND DIRECT ANY AND ALL INSURANCE CARRIERS, ATTORNEYS, AGENCIES, GOVERNMENT DEPARTMENTS, COMPANIES, INDIVIDUALS, AND/OR OTHER LEGAL ENTITIES ("PAYERS"), WHICH MAY ELECT OR BE OBLIGATED TO PAY, PROVIDE, OR DISTRIBUTE BENEFITS TO ME FOR ANY MEDICAL CONDITIONS, ACCIDENTS, INJURIES, OR ILLNESSES, PAST OR FUTURE ("CONDITION"), TO PAY DIRECTLY AND EXCLUSIVELY IN THE NAME OF DR. KODY R. JOHNSON, D.C., ("DR. JOHNSON" OR "CLINIC") SUCH SUMS AS MAY BE OWING TO DR. JOHNSON FOR CHARGES INCURRED BY ME WHICH RELATE, DIRECTLY OR INDIRECTLY, TO MY CONDITION ("CHARGES"), WITH SUCH PAYMENTS TO BE MADE EXCLUSIVELY IN THE NAME OF DR. KODY R. JOHNSON, D.C.. I FURTHER GRANT A CONTRACTUAL LIEN TO DR. JOHNSON WITH RESPECT TO MY CHARGES, HOWEVER, NOTHING IN THIS AGREEMENT SHALL NOT BE CONSTRUED AS AN ELECTION OF REMEDIES UNDER ANY STATUTORY LIEN LAW. FOR THE PURPOSES OF THIS AGREEMENT, "BENEFITS" SHALL INCLUDE, BUT NOT BE LIMITED TO, PROCEEDS FROM ANY SETTLEMENT, JUDGMENT, OR VERDICT, AS WELL AS ANY PROCEEDS RELATING TO COMMERCIAL HEALTH OR GROUP INSURANCE, ATTORNEY RETAINER AGREEMENTS, MEDICAL PAYMENTS BENEFITS, PERSONAL INJURY PROTECTION, NO-FAULT COVERAGE, UNINSURED AND UNDER INSURED MOTORISTS COVERAGE, THIRD-PARTY LIABILITY DISTRIBUTIONS, DISABILITY BENEFITS, WORKER'S COMPENSATION BENEFITS, AND ANY OTHER BENEFITS OR PROCEEDS PAYABLE TO ME FOR THE PURPOSES STATED HEREIN.

I FURTHER AGREE THAT, IN THE EVENT A PAYER REFUSES TO PAY DR. JOHNSON PURSUANT TO THIS AGREEMENT; I HEREBY ASSIGN ALL OF MY RIGHTS, REMEDIES, AND BENEFITS TO DR. JOHNSON TO THE 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 EITHER IN MY NAME OR IN THE CLINIC'S NAME, AND TO SETTLE OR OTHERWISE RESOLVE SUCH CAUSES OF ACTION AS THE CLINIC 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 CLINIC 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 CLINIC.

I AUTHORIZE THIS CLINIC 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 FURTHER AUTHORIZE AND DIRECT ALL PAYERS TO RELEASE TO DR. JOHNSON ANY INFORMATION REGARDING ANY COVERAGE OR BENEFITS WHICH I MAY HAVE INCLUDING, BUT NOT LIMITED TO, THE AMOUNT OF COVERAGE, THE AMOUNT PAID THUS FAR, AND THE AMOUNT OF ANY OUTSTANDING CLAIMS. I HEREBY DIRECT THIS CLINIC 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. JOHNSON TO ENDORSE/ SIGN MY NAME ON ANY AND ALL CHECKS LISTING ME AS A PAYEE WHICH ARE PRESENTED TO THIS CLINIC FOR PAYMENT OF AN ACCOUNT RELATING TO ME, MY SPOUSE, OR ANY OF MY DEPENDENTS. I FURTHER AUTHORIZE DR. JOHNSON 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 TO DR. JOHNSON FOR HIS SERVICES. THIS AGREEMENT DOES NOT CONSTITUTE ANY CONSIDERATION FOR THIS CLINIC TO AWAIT PAYMENTS AND IT MAY DEMAND PAYMENTS FROM ME IMMEDIATELY UPON RENDERING SERVICES AT ITS OPTION. AFTER 90 DAYS FROM MY DISCHARGE DATE, IF MY ACCOUNTS ARE NOT PAID IN FULL, THIS CLINIC RESERVES THE RIGHT TO REQUEST PAYMENT IN FULL AT THE CLINIC'S OR DR. JOHNSON'S OPTION; THIS IS REGARDLESS IF ANY SETTLEMENTS OR MONETARY AMOUNTS HAVE YET TO BE PAID. AMOUNTS THAT ARE PAST 90 DAYS DUE FROM THE ORIGINAL DISCHARGE DATE WILL BE CHARGED FIFTEEN-PERCENT INTEREST PER ANNUM AFTER 90 DAYS UNTIL ALL AMOUNTS DUE ARE PAID IN FULL. IF THIS CLINIC MUST TAKE ANY ACTION TO COLLECT AN OUTSTANDING BALANCE ON MY ACCOUNT, I WILL BE RESPONSIBLE FOR PAYMENT AND WILL REIMBURSE DR. JOHNSON FOR ALL COSTS OF SUCH COLLECTION EFFORTS, INCLUDING, BUT NOT LIMITED TO, ALL COURT COSTS AND ATTORNEY'S FEES.

THIS AGREEMENT SHALL NOT BE MODIFIED OR REVOKED WITHOUT THE MUTUAL WRITTEN CONSENT OF DR. JOHNSON AND MYSELF. I HEREBY REVOKE ANY PREVIOUSLY SIGNED AUTHORIZATIONS, WHETHER EXECUTED AT THIS CLINIC 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. JOHNSON AND/OR DR. HAGAN AND MYSELF. HOWEVER, SHOULD ANY PROVISION OF THIS AGREEMENT BE FOUND TO BE INVALID, ILLEGAL AND UNENFORCEABLE, OR FOR ANY REASON CEASE TO BE BINDING ON ANY PARTY HERETO, ALL OTHER PROVISIONS OF THIS AGREEMENT SHALL, NEVERTHELESS, REMAIN IN FULL FORCE AND EFFECT.

PATIENT NAME (PRINT): _____

PATIENT SIGNATURE: _____ DATE: _____/_____/_____

NAME OF CUSTODIAL PARENT OR LEGAL GUARDIAN (PRINT): _____

PATIENT SIGNATURE: _____ DATE: _____/_____/_____

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