MVA CHECKLIST

TODAYS DATE: / / | **DATE OF INCIDENT: / /**

PATIENT NAME:_____

3RD PARTY INSURANCE INFO

INS NAME:_____
ADDRESS:_____CITY_____
STATE:_____ZIP:_____
ADJUSTER NAME_____
PH: ( ) - FAX: ( ) - CLM#_____

YOUR AUTO INSURANCE INFO

MEDPAY? YES OR NO CLAIM#_____ AMOUNT$_____
INS NAME:_____
ADDRESS:_____CITY_____
STATE:_____ZIP:_____
ADJUSTER NAME_____
PH: ( ) - FAX: ( ) - PT SIGNED LIEN?

LIABLITY ESTABLISHED? YES OR NO WHOS AT FAULT? YOU OR OTHER PARTY?

ATTORNEY INFO

ATTORNEY? YES OR NO LIEN SIGNED BY ATTY? YES OR NO

ATTY NAME:_____ PH #:_____

IS HEALTH INS BEING BILLED? YES OR NO

INS CO NAME:_____
TX PLAN_____ (EX. 2XWK 1MONTH 2XWK 3MO)

ADDITONAL NOTES: _____

_____

_____ _____

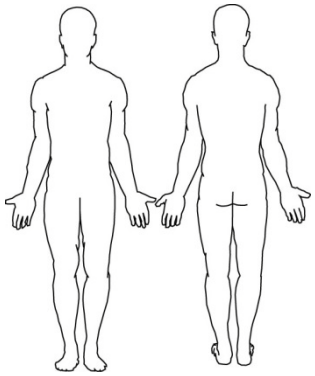
MVA DETAILED FORM RETURNED/COMPLETED? YES OR NO

American Specialty Health (ASH)
P.O. Box 509001, San Diego, CA 92150-9001
California Only Fax: 877.427.4777

Referred by _____ **Email**_____

Patient Name _____ Birth date _____ Sex: M/F
Address _____ City _____ SS# _____
State _____ Zip _____ Phone (_____) _____ Cell (_____)_____
Occupation _____ Employer _____ Work Phone (_____)_____
Address _____ City _____ State _____ Zip _____
Subscriber Name _____ Health Plan _____
Subscriber ID # _____ Group # _____ Spouse Name _____
Spouse Employer _____ City _____ State _____ Zip _____
Primary Care Physician Name _____ PCP Phone (_____)_____

MARK AN **X** ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS



DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

☐Headache ☐ Neck Pain ☐Mid-Back Pain ☐Low-Back Pain
☐Other_____

Is this? ☐Work Related ☐ Auto Related ☐N/A

Date Problem Began _____
How Problem Began _____

Current Complaint (how you feel today):

0 1 2 3 4 5 6 7 8 9 10
No Pain Unbearable Pain

How often are your symptoms present?
(Occasional) ☐ 0-25% ☐ 26-50% ☐ 51-75% ☐76-100% (Constant)

In the past week, how much has your pain interfered with your daily activities (e.g., work, social activities, or household chores)

No Interference 0 1 2 3 4 5 6 7 8 9 10 Unable to carry on any activities

In general would you say your overall health right now is:

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN FOR YOUR AREA(S) OF COMPLAINT? ☐ No ☐ Yes
Date(s) taken_____ **What areas were taken?** _____

Please check all of the following that apply to you:

☐ Alcohol/Drug Dependence
☐ Recent Fever
☐ Diabetes
☐ High Blood Pressure
☐ Stroke (Date) _____
☐ Corticosteroid Use (Cortisone, Prednisone, etc.)
☐ Taking Birth Control Pills
☐ Dizziness/Fainting
☐ Numbness in Groin/Buttocks
☐ Cancer/Tumor (Explain) _____
_____
☐ Osteoporosis
☐ Epilepsy/Seizures
☐ Other Health Problems (Explain) _____
_____
_____

☐ Prostate Problems
☐ Menstrual Problems
☐ Urinary Problems
☐ Currently Pregnant, # Weeks _____
☐ Abnormal Weight _____ Gain _____ Loss
☐Marked Morning Pain/Stiffness
☐ Pain Unrelieved by Position or Rest
☐ Pain at Night
☐ Visual Disturbances
☐ Surgeries _____
_____
☐ Tobacco Use - Type _____
Frequency _____/Day
Medication: _____
_____
_____

Family History: ☐Cancer ☐ Diabetes ☐ High blood Pressure
☐ Heart Problems/Stroke ☐ Rheumatoid Arthritis

I certify to the best of my knowledge, the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered and I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that my chiropractor or a clinical peer employed by ASH Networks may need to contact my physician if my condition needs to be co-managed. Therefore I give authorization to my chiropractor and/or ASH Networks to contact my physician, if necessary.

Patient Signature: _____ **Date:** _____

Tyra L. Beavers ***B.S. P.T.A. D.C***
310.859.7696 x2 310.859.7699 Fax
250 North Robertson, Suite 516, Beverly Hills, California 90211
Ph (310) 859.7696 x2 Fax (310) 859-7699

INFORMED CONSENT FOR CHIROPRACTIC TREATMENT AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physiotherapy, massage therapy, yoga, pilates and diagnostic x-rays, on my (or on the patient named below, for whom I am legally responsible) by the doctor, chiropractic assistant, intern, pilates/yoga instructor or massage therapist affiliated with the chiropractic office of Tyra L. Beavers D.C.

I understand that, as in the practice of medicine, in the practice of chiropractic care there are some risks to treatment, including but not limited to, fractures, disc injuries, strokes, dislocations, sprains, bruising and swelling. I do not expect the doctor to be able to anticipate and explain all risks and complications. I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts then known, and is in my best interests.

I have read, or have had read to me, the above consent. By signing below I agree to the above, and allow the doctor, chiropractic assistant, intern, pilates/yoga instructor or massage therapist affiliated with the chiropractic office of Tyra L. Beavers D.C. to perform such. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

_____
Patient's name (Please Print)

_____ _____
Patient Signature Date

_____ _____
Guardian's Signature Date

Tyra L. Beavers ***B.S. P.T.A. D.C***
310.859.7696 x2 310.859.7699 Fax
250 North Robertson, Suite 516, Beverly Hills, California 90211
Ph (310) 859.7696 x2 Fax (310) 859-7699

Disclosure of Fee's / Payment Policy

99202	Evaluation / Management – Expanded	$125.00
99203	Evaluation / Management – Detailed	$155.00
99212	Established Patient E&M – Limited	$125.00
99213	Established Patient E&M – Expanded	$155.00

97012	Traction, Mechanical	$45.00
97014	Electrical Stimulation	$45.00
97026	Infrared	$45.00
97110	Therapeutic Exercises	$55.00
97112	Neuromuscular	$55.00
97140	Manual Therapy Technique	$60.00
97035	Ultrasound	$45.00
97124	Full Body Massage 1 hr (Cash Patient)	$95.00

98940	Manipulative treatment 1-2 regions	$65.00
98941	Manipulative treatment 3-4 regions	$75.00
98942	Manipulative treatment 5 regions	$85.00
98943	Manipulative treatment extra spinal 1 or more regions	$65.00

I have read the above codes and fees and understand the cost of my care with my treating doctor. I understand that I am responsible for payment of all deductibles and co-payments/ co-insurance related to my care. I understand that if I have a balance for medical services not paid, I will make a minimum payment of $50.00 each month or 20% (auto-debit) of the outstanding balance whichever is greater. If my balance is not paid in a timely and monthly fashion, I promise to pay any and all collections, court, and attorney fees in the collection of my account. I further understand that if my treatment is associated with a personal injury or accident claim, all medical bills will be paid at 100% of the above fee schedule regardless of the outcome of my case. I understand that if a check or debit is returned for insufficient funds, I will be charged a $25.00 service charge. I further understand that if my insurance company declines payment, I authorize Tyra Beavers, DC to file small claims on my behalf against my insurance company as a method of collection. I further understand that I will be present at the court date if needed. I have read and fully understand the above financial terms and prices.

Print Name: _____

Signature: _____ Date: _____

MOTOR VEHICLE CRASH FORM (Page 1)

Patient Name:_____ Date:_____
Date of Injury:_____Time of Injury:_____ ☐AM ☐PM
City where crash occurred:_____ Was the street wet or dry?☐Wet ☐Dry
Street (location) where crash occurred: _____
What is the estimated damage to your vehicle? $_____
Who made damage estimates on your vehicle? _____
Who owns the vehicle you were involved in: _____

☐ Yes ☐ No Did the Police come to the accident scene?
☐ Yes ☐ No Did the police make a written report?
☐ Yes ☐ No Were any photographs taken of your vehicle? If yes, who took them:

DESCRIBE HOW THE CRASH HAPPENED:

_____

_____

_____

COLLISION DESCRIPTION-TYPE:

Check all that apply to you. Indicate which type of car crash you were involved in:

	Single-car Crash		Two-vehicle Crash		Three or more vehicles
	Rear-end Crash		Side Crash		Rollover
	Head-on Crash		Hit guard rail, tree, or object		Ran off the road

	Other (Describe):

INDICATE YOUR SEATING POSITION:

	Driver		Front Passenger		Left Rear Passenger		Right Rear Passenger

MOTOR VEHICLE CRASH FORM (Page 2)

DESCRIBE THE VEHICLE YOU WERE IN:

Model, Make, and Year:

	Small-sized Car		Mid-sized car		Large-sized Car
	Pick-up Truck		Van		Sport Utility Vehicle
	2 Door vehicle		4 Door vehicle		Large Truck, bus, or semi-truck
	Sedan		Hatchback		Stationwagon

DESCRIBE THE OTHER VEHICLE:

Model, Make, and Year	Unknown

	Small Car		Mid-sized Car		Van
	Pick-up Truck/Sports Utility		Full-sized Car		Large truck, Bus, or Semi-truck

AT THE TIME OF IMPACT YOUR VEHICLE WAS:

	Slowing Down		Gaining Speed
	Stopped		Moving at steady speed

AT THE TIME OF IMPACT THE OTHER VEHICLE WAS:

	Slowing Down		Gaining speed		Unknown Speed
	Stopped		Moving at steady speed		Other:

DURING AND AFTER THE CRASH, YOUR VEHICLE:

	Kept going straight, not hitting anything		Spun around, not hitting anything
	Kept going straight, hitting car in front		Spun around, hitting another car
	Was hit by another vehicle		Spun around, hitting object other than car

MOTOR VEHICLE CRASH FORM (Page 3)

INDICATE IF YOUR BODY HIT SOMETHING OR WAS HIT BY ANY OF THE FOLLOW: please draw lines from the body regions on the left side and match to the right side.

BODY REGION	OBJECT YOU HAD CONTACT WITH
Head	Windshield
Face	Side Window
Shoulder	Side Door
Arm/Hand	Dashboard
Front Chest Wall	Knee Bolster/Glove Compartment
Side Chest Wall	Seatbelt
Hip/Abdomen	Frame of Car Near Windows
Knee	Roof of Vehicle
Leg	Another Occupant/Animal
Foot	Other

CHECK IF ANY OF THE FOLLOWING VEHICLE PARTS BROKE, BENT, OR WERE DAMAGED IN YOUR CAR:

	Windshield		Seat Frame		Knee Bolster
	Steering Wheel		Side-Rear Window		Other
	Dash		Mirror		Other

ALL TYPES OF COLLISIONS indicate those relevant to your case.

Yes	No	
		Did any of the front or side structures, such as the side door, dashboard, or floorboard of your car dent inward during the crash?
		Did the side door touch your body during the crash?
		Did your body slide under the seatbelt?
		Was the door(s) of your vehicle damaged to the point where you could not open the door?
		Did an airbag deploy in your vehicle during the crash?
		Were you intoxicated (alcohol) at the time of the crash?

MOTOR VEHICLE CRASH FORM (Page 4)

SEATBELT USAGE AND STEERING WHEEL HAND PLACEMENT:

Yes	No	
		Were you wearing a seatbelt? If yes, does your seatbelt have a: ☐ Lap & Shoulder Strap, ☐ Lap belt only
		Indicate if you had any portion of your seatbelt positioned behind your back or shoulder.
		Were you holding onto the steering wheel (driver only) at the time of impact? If yes indicate where each hand was positioned (use time clock face as your reference point) Left Hand: ☐ Not on Wheel, ☐ Yes, Hand at _____ o' clock, ☐ Hand elsewhere Right Hand: ☐ Not on wheel, ☐ Yes, hand at _____ o' clock, ☐ Hand elsewhere

REAR-END COLLISIONS ONLY answer this section only if you were hit from the rear.

Describe your vehicle's head restraint system:

☐ Movable/adjustable head restraint ☐ Fixed, non-moveable head restraint
☐ No headrests in my vehicle ☐ Bench seat in your vehicle without head restraint

Please indicate how your <u>head restraints</u> was positioned at the time of crash (if present):

☐ At the top of the back of your head ☐ Midway height of the back of your head
☐ Lower height of the back of your head ☐ Located at the level of your neck
☐ Level of your shoulder blades

BRUISING AFTER THE CRASH

Yes	No	
		Did your body have any bruising (areas that are visibly black and blue) after the crash? If yes indicate where: _____

AWARENESS AND BODY POSITION DESCRIPTIONS: check all areas that apply to you.

	You were unaware of the impending collision. You did not see or hear brakes prior to the impact.
	You were aware of the impending crash and relaxed before the collision.
	You were aware of the impending crash and braced yourself.
	Your body, torse, and head were facing straight ahead.
	You had your head and/or torso turned at the time of collision: Turned to the left, Turned to the right Describe how far you were turned/ twisted and why?
	You were leaning forward at the time of impact in a gap between your body and the seatback
	Your torso and body was positioned normally against the seatback with no gaps due to leaning/twisting.

PAIN INTENSITY
INSTRUCTION SHEET

PATIENT: Be certain to read the following pain categorical and indicate which level best represents how severe your current pain level is. If you do not understand these instructions be sure to ask the Doctor.

Pain Intensity	**None**	**MILD**			**MODERATE**				**SEVERE**		
PAIN LEVEL	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
PAIN LEVEL AND THE EFFECT THAT PAIN HAS ON YOUR ABILITY TO PERFORM ACTIVITY	No Pain	Annoying Pain Level Only Able to Perform All Home, Work, Sport, and Recreational Activities.			Pain Levels Now Cause you to Slow Down. You Are Able to Do Activities at Home and Work, But They Take You Longer to Do or You Need to Take Breaks.				Pain Levels Must Prohibit Your Ability to Perform Some Activities. You Must Have Some Inability to Do Certain Activities. Must Have Some Difficulty Sleeping.		
HOW DOES THE PAIN FEEL?	No Pain	Ache, Dull Soreness, Stiffness			Hurting Pain, Very Sore, Limited Motion				Sharp Pain, Stabbing Pain, Jabbing Pain		
LEVEL	********	MILD			MODERATE				SERVERE		

A LEVEL 10 PAIN IS EQUAL TO THE MOST SEVERE PAIN YOU HAVE EVER HAD!!

A Level 10 Pain equates to having a baby pain or having the most severe toothache or kidney stone type of pain!!

PAIN INTENSITY

PATIENT: _____ DATE: _____

For section 1, describe on a scale of 1-10 how intense your pain or symptoms are. This includes the amount of aching, soreness, hurting, pain, numbness, and/or tingling levels present currently. A zero (0) indicates that no symptoms exists, 1-3 pain level is a minimum level and indicates that your pain is an annoyance only. A 4 pain is a slight level or where pain doing activity begins to cause some disability. A 5-7 pain is moderate in severity and has to restrict or limit your activity ability to a significant degree. A 8-10 pain level is severe and indicates that your pain intensity is to point where you have complete inability to perform some tasks. For **SECTION 2**, describe how frequent you have symptoms such as pain, numbness, and tingling in the respected areas. Please pay attention to the headache portion.

SECTION 1. CURRENT PAIN INTENSITY LEVELS

Circle the box following the are of pain that best indicates your overall average-usual pain severity today.

Pain Intensity	None	**MINIMAL** Discomfort/ Ache/ Stiff	**SLIGHT-TO-MODERATE** Hurts/ Sore/ Bearable Sensation	**SEVERE** Sharp/ Intense Pain

Headache	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Neck Pain/ Soreness	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Arm/ Hand Symptoms	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Mid Back Pain	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Low Back Pain	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Leg/ Foot Symptoms	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

SECTION 2a. CURRENT PAIN FREQUENCY LEVELS

Circle the box following the area of pain that best indicates the average percentage of time you have pain today.

Pain Frequency	**None**	**Occassional**	**Intermittent**	**Frequent**	**Constant**

Neck Pain/ Soreness	**0%**	**10%**	**20%**	**30%**	**40%**	**50%**	**60%**	**70%**	**80%**	**90%**	**100%**
Arm/ Hand Symptoms	**0%**	**10%**	**20%**	**30%**	**40%**	**50%**	**60%**	**70%**	**80%**	**90%**	**100%**
Mid-Back Pain	**0%**	**10%**	**20%**	**30%**	**40%**	**50%**	**60%**	**70%**	**80%**	**90%**	**100%**
Low-Back Pain	**0%**	**10%**	**20%**	**30%**	**40%**	**50%**	**60%**	**70%**	**80%**	**90%**	**100%**
Leg/ Foot Symptoms	**0%**	**10%**	**20%**	**30%**	**40%**	**50%**	**60%**	**70%**	**80%**	**90%**	**100%**

SECTIONS 2b. CURRENT HEADACHE FREQUENCY & DURATION

During the past week or since the accident/injury if applicable (if less than one week) indicate how frequently you have had headaches and/or migraines. Be sure to indicate how long each headache typically lasts.

A. How frequently do you have headaches currently?

☐No headaches ☐Once a Week ☐4 times a Week
☐Once a Month ☐Twice a Week ☐5 times a Week
☐ Twice a Month ☐3 times a Week ☐Almost Daily

B. How many hours does you typical headache last? _____ Hours?

POST-TRAUMATIC SYMPTOM QUESTIONNAIRE

PATIENT INSTRUCTIONS: It is important for this section to be filled out in detail. Look at each symptom listed in the left column and make a single check mark or several check marks in the appropriate columns for the specific symptom which applies to you. Be certain to indicate when you had the beginning of any of the following symptoms. Leave the row blank if the symptom listed does not apply to you.

Symptom List	BEGAN IN LESS THAN 24 HOURS AFTER INJURY	BEGAN 1 TO 7 DAYS AFTER INJURY	YOU HAVE SYMPTOMS CURRENTLY	HAD SIMILAR SYMPTOMS ONE YEAR BEFORE THIS INJURY
Headache/ Migraine				
Dizziness				
Tinnitus (ear ringing)				
Blurry Vision				
Memory Problems				
Poor Concentration				
Irritability				
Balance Problems				
Loss of Coordination				
Sensitivity to Sound				
Sensitivity to Light				
Fatigue				
Anxiety				
Pain/ Difficulty Swallowing				
Jaw Pain/ Soreness				
Neck Pain/ Soreness/ Aching				
Neck Stiffness				
Shoulder Pain/ Stiffness				
Arm Pain/ Tingling/Numbness				
Wrist/Hand/Finger Pain/Numbness				
Weakness in Arm/ Legs				
Upper/ Middle Back Pain/ Soreness				
Rib Cage pain				
Low Back Pain/ Soreness/ Aching				
Hip Pain				
Leg Pain				
Leg Numbness/ Tingling				
Pain Shoots Down Back of Legs				
Pain Primarily in Front of Thighs				
Knee Pain				
Ankle/ Foot Pain				
Other				

SYMPTOM INTENSITY AND FREQUENCY FORM

Patient: _____ Date: _____

For **SECTION 1**, describe on a scale of 1-10 how intense your pain or symptoms are. This includes the amount of aching, soreness, hurting, pain, numbness, and/or tingling levels present currently. A **zero (0)** indicates that no pain symptoms exist. A **1-3 pain** level is a minimum level and indicates that your pain is an annoyance only. A **4 pain** is a slight level or where pain doing activity begins to cause some disability. A **5-7 pain** is moderate in severity and has to restrict or limit your activity ability to a significant degree. An **8-10** pain level is severe and indicates that your pain intensity is to a point where you have complete inability to perform some tasks. For **SECTION 2**, describe how frequent you have symptoms such as pain, numbness, and tingling in the respected areas. Please pay attention to the headache portion.

SECTION 1. CURRENT PAIN INTENSITY LEVELS

Circle the box following the area of pain that best indicates your overall average-usual pain severity today.

Pain Intensity	None	**MINIMAL** Discomfort/Ache/Stiff			**SLIGHT-TO-MODERATE** Hurts/Sore/Bearable Sensation			**SEVERE** Sharp/Intense Pain			
Headache	0	1	2	3	4	5	6	7	8	9	10
Neck Pain / Soreness	0	1	2	3	4	5	6	7	8	9	10
Arm / Hand Symptoms	0	1	2	3	4	5	6	7	8	9	10
Mid Back Pain	0	1	2	3	4	5	6	7	8	9	10
Low Back Pain	0	1	2	3	4	5	6	7	8	9	10
Leg / Foot Symptoms	0	1	2	3	4	5	6	7	8	9	10

SECTION 2a. CURRENT PAIN FREQUENCY LEVELS

Circle the box following the area of pain that best indicates the average percentage of time you have pain today.

Pain Frequency	None	**Occasional**			**Intermittent**			**Frequent**		**Constant**	
Neck Pain / Soreness	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Arm / Hand Symptoms	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Mid Back Pain	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Low Back Pain	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Leg / Foot Symptoms	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%

SECTION 2b. CURRENT HEADACHE FREQUENCY & DURATION

During the past week or since the accident/injury if applicable (if less than one week) indicate how frequently you have had headaches and/or migraines. Be sure to indicate how long each headache typically lasts.

A. How frequently do you have headaches currently?

☐ No headaches ☐ Once a week ☐ 4 times a week
☐ Once a month ☐ Twice a Week ☐ 5 Times a Week
☐ Twice a month ☐ 3 Times a Week ☐ Almost Daily

B. How many hours does your typical headache last? _____ Hours

Tyra L. Beavers ***B.S. P.T.A. D.C***
310.859.7696 x2 310.859.7699 Fax
250 North Robertson, Suite 516, Beverly Hills, California 90211
Ph (310) 859.7696 x2 Fax (310) 859-7699

Auto Accident Questionnaire

Patient Name: _____ Date: _____

1. What was the date of your accident?
2. Do you have Auto Insurance? ☐Yes ☐No
   If "Yes" what type of personal Health Insurance? _____ PPO or HMO
3. Have you reported that accident to your insurance company? ☐Yes ☐No
4. Please provide your Claim #_____
5. Do you have Medpay? ☐Yes ☐No
6. Have you completed an application for benefits form*? ☐Yes ☐No
   a. * Your insurance company will send you this form, and it must be completed in order for you to be eligible for the medical coverage you are entitled to through your auto insurance policy.
7. Have you seen any other type of health care providers and what types of treatment have you received for care relating to the accident? ☐Yes ☐No

   _____

   _____

   _____

8. Have you contacted a lawyer regarding your accident? ☐Yes ☐No
   a. Lawyer: _____ Phone: _____
9. Has Liability been established? ☐Yes ☐No
   a. Who's at Fault? _____
10. Please give a brief description of the accident: _____

    _____

    _____

    _____

    _____

Tyra L. Beavers ***B.S. P.T.A. D.C***
310.859.7696 x2 310.859.7699 Fax
250 North Robertson, Suite 516, Beverly Hills, California 90211
Ph (310) 859.7696 x2 Fax (310) 859-7699

NOTICE OF DOCTOR LIEN

Patient:
Date of Accident:

I do hereby authorize Tyra Beavers D.C. to furnish you, my attorney, with a full report of treatment 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 owing for chiropractic service rendered me both by reason of this accident and my reason of any other bills that are due for office and to 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 fo the injuries for which I have been treated for injuries in connection therewith.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by Dr. Tyra Beavers for services rendered me and that this agreement is made solely for said Doctor to give additional protection and in consideration of 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 charge or addition of attorney(s) used by me in connection with this accident, and I instruct my attorney to do the same and promptly deliver a copy of this lien to any substituted or added attorney(s).

Please acknowledge this letter by signing below and returning to Dr. Tyra Beavers. I have been advised that if my attorney does not wish to cooperate in protecting said doctor interest, the Doctor will not await payment but may declare the entire balance due and payable. I further understand the cost of my Chiropractic treatment and believe her charges to be reasonable and necessary expense. I also direct my attorney to pay said doctor the full cost of treatment in my case.

Dated: _____ Patient's Signature: _____

I, the undersigned certify as follows: I am an active member of the State Bar of California in good standing; I am authorized to sign this document on behalf of my law office; said office is duly designated to represent said patient in connection herewith; said office agrees to honor and uphold all the fore-going provisions listed above, and all legal, equitable, and ethical obligations arising here from; and, said office has and shall maintain a true copy hereof.

Attorney Name: _____

Address: _____

Dated: _____ Attorney Signature: _____

Claim No: _____ Insurance Co: _____

Tyra L. Beavers ***B.S. P.T.A. D.C***
310.859.7696 x2 310.859.7699 Fax
250 North Robertson, Suite 516, Beverly Hills, California 90211
Ph (310) 859.7696 x2 Fax (310) 859-7699

HIPAA NOTICE OF PRIVACY PRACTICES

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

This Practice is committed to maintaining the privacy of your protected health information ("PHI"), which includes information about your health condition and the care and treatment you receive from the Practice. The creation of a record detailing the care and services you receive helps this office to provide you with quality health care. This Notice details how your PHI may be used and disclosed to third parties. This Notice also details your rights regarding your PHI. The privacy of PHI in patient files will be protected when the files are taken to and from the Practice by placing the files in a box or brief case and kept within the custody of a doctor or employee of the Practice authorized to remove the files from the Practice's office.

NO CONSENT REQUIRED

The Practice may use and/or disclose your PHI for the purposes of:

(a) Treatment – In order to provide you with the health care you require, the Practice will provide your PHI to those health care professionals, whether on the Practice's staff or not, directly involved in your care so that they may understand your health condition and needs.
(b) Payment – In order to get paid for services provided to you, the Practice will provide your PHI, directory or through a billing service, to appropriate third party payers, pursuant to their billing and payment requirements.
(c) Health Care Operations – In order for the Practice to operate in accordance with applicable law and insurance requirements and in order for the Practice to continue to provide quality and efficient care, it may be necessary for the Practice to compile, use and/or disclose your PHI.

The Practice may use and/or disclose your PHI, without a written Consent from you, in the following additional instances:

(a) De-identified information – Information that does not identify you and, even without your name, cannot be used to identify you.
(b) Business Associate – To a business associate if the Practice obtains satisfactory written assurance, in accordance with applicable law, that the business associate will appropriately safeguard your PHI. A business associate is an entity that assists the Practice in undertaking some essential function, such as a billing company that assists the office in submitting claims for payment to insurance companies or other payers.
(c) Personal Representative – To a person who, under applicable law, has the authority to represent you in making decisions related to your health care.
(d) Emergency situations –
    a. For the purpose of obtaining or rendering emergency treatment to you provided that the Practice attempts to obtain your Consent as soon as possible; or
    b. To a public or private entity authorized by law or by its charter to assist in disaster relief efforts, for the purpose of coordinating your care with such entities in an emergency situation.
(e) Communication barriers – If, due to substantial communication barriers or inability to communicate, the Practice has been unable to obtain your Consent and the Practice determines, in the exercise of its professional augment, that your Consent to receive treatment is clearly inferred from the circumstances.
(f) Public Health Activities – Such activities include, for example, information collected by a public health authority, as authorized by law, to prevent or control disease and that does not identify you and, even without your name, cannot be used to identify you.
(g) Abuse, Neglect, or Domestic Violence – to a government authority if the Practice is required by law to make such disclosure. If the Practice is authorized by law to make such a disclosure, it will do so if it believes that the disclosure is necessary to prevent serious harm.

Tyra L. Beavers ***B.S. P.T.A. D.C***
310.859.7696 x2 310.859.7699 Fax
250 North Robertson, Suite 516, Beverly Hills, California 90211
Ph (310) 859.7696 x2 Fax (310) 859-7699

(h) Health Oversight Activities – Such activities, which must be required by law, involve government agencies and may include, for example, criminal investigations, disciplinary actions, or general oversight activities relating to the community's health care system.
(i) Judicial and Administrative Proceeding – For example, the Practice may be required to disclose your PHI in response to a court order or a lawfully issued subpoena.
(j) Law Enforcement Purposes – In certain instances, your PHI may have to be disclosed to a law enforcement official. For example, your Phi may be the subject for a grand jury subpoena. Or, the Practice may disclose your PHI if the Practice believes that your death was the result of criminal conduct.
(k) Coroner or Medical Examiner – The Practice may disclose your PHI to a coroner or medical examiner for the purpose of identifying you or determining your cause of death.
(l) Organ, Eye or Tissue Donation – If you are an organ donor, the Practice may disclose your PHI to the entity to whom you have agreed to donate your organs.
(m) Research – If the Practice is involved in research activities, your PHI may be used, but such use is subject to numerous governmental requirements intended to protect the privacy of your PHI and that does not identify you and, even without your name, cannot be used to identify you.
(n) Avert a Threat to Health or Safety – The Practice may disclose your PHI if it believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to an individual who is reasonably able to prevent or lessen the threat.
(o) Workers' Compensation – If you are involved in a Workers' Compensation claim, the Practice may be required to disclose your PHI to an individual or entity that is part of the Workers' Compensation system.

Appointment Reminders

- Your health care provider or a staff member may disclose your health information to contact you to provide appointment reminders. If you are not at home to receive an appointment reminder, a message will be left on your answering machine, voice mail, or with the person who answers the call.
- You have the right to refuse us authorization to contact you to provide appointment reminders. If you refuse us authorizing, it will not affect the treatment we provide to you.

Electronic Communication: Email, Fax, or Text / Medical Records Release (PHI)

- We may use these unsecure methods of communication to obtain medical records. You may opt out of those methods in writing. By signing below you adhere to these risks.

Sign-in Log

This Practice maintains a sign-in log for individuals seeking care and treatment in the office. This sign-in sheets are located in a position where staff can readily see who is seeking care in the office, as well as the individual's location within the Practice's office suite. This information may be seen by, and is accessible to, others who are seeking care or services in the Practice's offices.

Family / Friends

The Practice may disclose to your family member, other relative, a close personal friend, or any other person identified by you, your PHI directly relevant to such person's involvement with your care or the payment for your care unless you direct the Practice to the contrary. This Practice may also use or disclose your PHI to notify or assist in the notification (including identifying or locating) a family member, a personal representative, or another person responsible for your care, of your location, general condition or death. However, in both cases, the following conditions will apply:

a) If you are present at or prior to the use or disclosure of your PHI, the Practice may use or disclose your PHI if you agree, or if the Practice can reasonably infer from the circumstances, based on the exercise of its professional judgment that you do not object to the use or disclosure.

Tyra L. Beavers ***B.S. P.T.A. D.C***
310.859.7696 x2 310.859.7699 Fax
250 North Robertson, Suite 516, Beverly Hills, California 90211
Ph (310) 859.7696 x2 Fax (310) 859-7699

b) If you are not present, the Practice will, in the exercise of professional judgment, determine whether the use or disclosure is in your best interests and, if so, disclose only the PHI that is directly relevant to the person's involvement with your care.

AUTHORIZATION
Uses and/or disclosures, other than those described above, will be made only with your written Authorization.

Your Right to Revoke Your Authorization
You may revoke your authorization to us at any time; however, your revocation must be in writing.

Restrictions
You may request restrictions on certain use and/or disclosure of your PHI as provided by law. However, the Practice is not obligated to agree to any requested restrictions. To request restrictions, you must submit a written request to the Practice's Privacy Officer. In your written request, you must inform the Practice of what information you want to limit, whether you want to limit the Practice's use or disclosure, or both, and to whom you want the limits to apply. If the Practice agrees to your request, the Practice will comply with your request unless the information is needed in order to provide you with emergency treatment.

You Have a Right to
Inspect and obtain a copy your PHI as provided by 45 CFR 164.528. To inspect and copy your PHI, you are requested to submit a written request to the Practice's Privacy Officer. The Practice can charge you a fee for the cost of copying, mailing or other supplies associated with your request.

Receive confidential communications or PHI by alternative means or at alternative locations. You must make your request in writing to the Practice's Privacy Officer. The Practice will accommodate all reasonable requests.

Prohibit report of any test, examination or treatment to your health plan or anyone else for which you pay in cash or by credit card.

Receive an accounting of disclosures of your PHI as provided by 45 CFR 164.528. The request should indicate in what form you want the list (such as paper or electronic copy).

Receive a paper copy of this Privacy Notice from the Practice upon request to the Practice's Privacy Officer.

Request copies of PHI in electronic format if this office maintains your records in that format.

Amend your PHI as provided by 45 CFR 164.528. To request an amendment, you must submit a written request to the Practice's Privacy Officer. You must provide a reason that supports your request. The Practice may deny your request if it is not in writing. If you do not provide a reason in support of your request, if the information to be amended was not created by the Practice (unless the individual or entity that created the information is no longer available), if the information is not part of your PHI maintained by the Practice, if the information is not part of the information you would be permitted to inspect and copy/ and/or if the information is accurate and complete. If you disagree with the Practice's denial, you will have the right to submit a written statement of disagreement.

Receive notice of any breach of confidentiality of your PHI by the Practice.

Complain to the Practice or to the Office of Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, HHH Building, Washington, D.C. 20201, (202) 619-0257. Email: ocrmail@hhs.gov if you believe your privacy rights have been violated. To file a complaint with the Practice, you must contact the Practice's Privacy Officer. All complaints must be in writing.

I acknowledge that I was provided a copy of the Notice of Privacy Practices that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

Tyra L. Beavers ***B.S. P.T.A. D.C***
310.859.7696 x2 310.859.7699 Fax
250 North Robertson, Suite 516, Beverly Hills, California 90211
Ph (310) 859.7696 x2 Fax (310) 859-7699

PRACTICE'S REQUIREMENTS

1. **The Practice:**

   - **Is required by federal law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI.**
   - **Is required to abide by the terms of this Privacy Notice.**
   - **Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for your entire PHI that it maintains.**
   - **Will distribute any revised Privacy Notice to you prior to implementation.**
   - **Will not retaliate against you for filing a complaint.**

Patient Name: _____

Patient Signature: _____ **Date:** _____

Authorized Facility Signature: _____ **Date:** _____