Trostel Chiropractic Ltd.
2487 N. Monroe St.
Decatur, IL 62526
217-872-5452

History Form

Patient Information

Name_____ Date_____
Date of Birth_____ Social Security # _____
Address_____ City_____
State_____ Zip_____ Home Phone_____
Work Phone_____ Cell Phone_____
Primary Care Physician_____ Phone_____
Gender: Male or Female
Marital Status: Married Single Divorced Legally Separated Widowed
Spouses Name _____

Emergency Contact Information

Name _____ Phone #_____
Address_____ City_____
State_____ Zip_____

Insurance Information

Carrier Name_____
Card Holder Name _____
Card Holder Date of Birth _____
Card Holder Social Security # _____

Main Problem

What pain caused you to come to the office?_____
_____
What Caused this pain? _____
_____
When did this pain start?_____
How long does this pain last?_____

Dr. Signature _____ Date _____

Patient Intake Form

Name: ______________________________

For Office Use Only

Date: ______________

Acct #: ______________

Pt. Height: __________

Pt. Weight: __________

Pt. BMI: __________

Pt.Blood Pressure: ______

Race (circle only 1) American Indian Alaska Native

Asian White

Black or African American

Native Hawaiian Other Pacific Islander

Declined to State

Ethnicity (circle only 1) Declined to State Hispanic or Latino

Not Hispanice or Latino

Preferred Language ____

Are your present problems due to an injury? ❑Yes ❑No

Enter the date of the injury:__________

Was the injury? ❑ Job Related ❑Auto Accident ❑Personal Injury ❑Other: ______________

Has the accident been reported? ❑Yes ❑No If so, to whom? ❑To Employer ❑Auto Carrier ❑Other

Briefly describe the accident, injury or illness:

____

____

____

____

List symptoms experienced immediately after the injury: Choose the severity associated with the symptom

________________________ ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Remarkably Severe

Frequency of Pain ❑Occasional ❑Intermittent ❑Frequent ❑None

Type of Pain ❑Aching ❑Burning ❑Dull ❑Pulling ❑Sharp ❑Shooting ❑Stabbing ❑Stinging ❑Throbbing❑None

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List any tests, studies or medications received for this condition:

❑Tests/Studies:____

❑Medications:____

Were you admitted to the hospital due to this condition: ❑Yes ❑No

If yes, what hospital? ____________________ Transported by? ❑Ambulance ❑Police ❑Other

Date Admitted: ______________ Date Released: ______________ Length of Stay: ______________

List symptoms you are experiencing today: Choose the severity level associated with each symptom

_________________________ ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Remarkably Severe

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Type of Pain ❑Aching ❑Burning ❑Dull ❑Pulling ❑Sharp ❑Shooting ❑Stabbing ❑Stinging ❑Throbbing❑None

Do you have any current work restrictions due to this condition? Off work:❑Yes ❑No ❑Previously From: _______ To: ___________ Light duty: ❑Yes ❑No ❑Previously (If yes, what are/were your restrictions?) ____

Do you suffer from any condition other than that for which you are now consulting us? ❑Yes ❑No

____

List any past conditions you may have had:

____
____
____
____
____
____

HABITS

❑Current Every Day Smoker ❑Current Some Day Smoker ❑Former Smoker ❑Never Smoker ❑Drinking Alchohol: (Cups/day): ____ ❑Coffee Cups/Day: _____ ❑Soft Drink Bottles or Cans/Day: _____ ❑Water Cups/Day: _____

EXERCISE

FAMILY HISTORY

❑None		Diabetes	Cancer	Back Pain	Other
❑Moderate	Mother	❑	❑	❑	❑
❑Daily	Father	❑	❑	❑	❑
	Sibling(s)	❑	❑	❑	❑

Are you taking any medication (prescription or over-the-counter)? ❑Yes ❑No

If Yes, please indicate the following:

Medication: _____ Medication: _____

Route: Oral Intravenous Other: _____ Route: Oral Intravenous Other: _____

Frequency: _____ Frequency: _____

Began Use: _____ Began Use: _____

Discontinued Use: _____ Discontinued Use: _____

Medication: _____ Medication: _____

Route: Oral Intravenous Other: _____ Route: Oral Intravenous Other: _____

Frequency: _____ Frequency: _____

Began Use: _____ Began Use: _____

Discontinued Use: _____ Discontinued Use: _____

Have you taken any medications in the past? ❑Yes ❑No If yes, which ones?: _____

Do you have allergies? ❑Yes ❑No

If Yes, please indicate the following:

Allergy: _____ Allergy: _____

Reaction: _____ Reaction: _____

Start Date: _____ Start Date: _____

End Date: _____ End Date: _____

Allergy: _____ Allergy: _____

Reaction: _____ Reaction: _____

Start Date: _____ Start Date: _____

End Date: _____ End Date: _____

Have you ever had any surgeries? ❑Yes ❑No (If yes, enter type and approximate date of surgery.)

Have you ever had X-rays taken? ❑Yes ❑No When? _____ For what ailments were these X-rays taken? _____

OPERATIONS AND PROCEDURES

Please check the box for each current or past symptom listed.

GENERAL SYMPTOMS	GASTRO-INTESTINAL	EYE/EAR/NOSE/THROAT	RESPIRATORY
❑ Allergy(What) _____	❑ Belching or Gas	❑ Asthma	❑ Chest Pain
❑ Bronchitis	❑ Colon Trouble		❑ Deafness
❑ Chronic Cough ❑ Headache		❑ Constipation	❑ Earache
❑ Spitting Blood ❑ Convulsions		❑ Diarrhea	❑ Ear Discharge

❑ Spitting Phlegm ❑ Dizziness ❑ Gall Bladder

❑ Ear Noises ❑ Fainting ❑ Hemorrhoids

(piles) ❑ Thyroid Problems GENERAL SYMPTOMS GASTRO-INTESTINAL

EYE/EAR/NOSE/THROAT GENITO-URINARY

❑ Loss of Sleep ❑ Nausea ❑ Nasal Obstruction ❑ Blood in Urine

❑ Loss of Weight ❑ Stomach Pain ❑ Nose Bleeds

❑ Frequent Urination ❑ Nervousness ❑ Vomiting

❑ Pain in Eyes ❑ Urination Control ❑ Night Sweats ❑ Vomiting Blood

❑ Poor Vision ❑ Kidney Infection ❑ Numbness in _____ ❑ Heart Burn

❑ Blurred Vision ❑ Kidney Stones ❑ Wheezing

❑ Bloody Stools ❑ Sinusitis ❑ Painful Urination

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?

❑Appendicitis ❑Anemia ❑Heart Disease ❑Arthritis

❑Pneumonia ❑Measles ❑Goiter ❑Epilepsy

❑Rheumatic Fever ❑Mumps ❑Influenza ❑Mental Disorder

❑Polio ❑Chicken Pox ❑Pleurisy ❑Lumbago

❑Tuberculosis ❑Diabetes ❑Alcoholism ❑Eczema

❑Whooping Cough ❑Cancer ❑Venereal Disease ❑HIV Positive

I hereby authorize the doctor to examine and treat my condition as he/she deems appropriate through the use of chiropractic health care, and I give authority for these procedures to be performed. It is understood and agreed the imaging is for examination only and the negatives will remain the property of this office, being on file where they may be viewed.

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

TROSTEL CHIROPRACTIC CLINIC
FINANCIAL DISCLOSURE

I UNDERSTAND THAT PAYMENT IS DUE WHEN SERVICES ARE RENDERED AND I WILL BE RESPONSIBLE FOR SUCH PAYMENT AT THAT TIME. SHOULD THIS ACCOUNT BECOME DELINQUENT FOR ANY REASON, I AM ALSO RESPONSIBLE FOR COLLECTION AND/OR ATTORNEY FEES.

FOR ANY CHECK THAT IS RETURNED TO US DUE TO INSUFFIECIENT FUNDS, ACCOUNT CLOSED, ETC. YOU WILL BE CHARGED A $25.00 SERVICE FEE.

IN THE EVENT YOUR ACCOUNT IS PAST DUE, IT MAY BE TURNED OVER TO A COLLECTION AGENCY. IF YOUR ACCOUNT IS NOT PAID IN FULL AND THIS ACCOUNT IS TURNED OVER TO A COLLECTION AGENCY AND/OR ATTORNEY, THEN YOU AGREE TO BE RESPONSIBLE FOR ALL REASONABLE FEES NECESSARY FOR THE COLLECTION OF THE DELINQUENT ACCOUNT INCLUDING, BUT NOT LIMITED TO, COLLECTION AGENCY FEES OF 50% OF THE BALANCE DUE AND COSTS AND REASONABLE ATTORNEY'S FEES OF 33% OF THE BALANCE.

SIGNATURE OF PATIENT FOR FINANCIAL DISCLOSURE DATE

SIGNATURE OF LEGAL GUARDIAN/NEXT OF KIN FOR FINANCIAL DISCLOSURE DATE

WITNESS DATE

Trostel Chiropractic, Ltd.
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Trostel Chiropractic, Ltd. Prides itself for the close relationships we have with our patients, but we may not be sure in every case whether a family member or friend is involved in your care. **We ask that you complete this form to inform us of those individuals.** We will enter this information in our computer systems to assist our staff in verifying a person's involvement. By identifying your caregivers, you can avoid problems that may arise when our staff does not know a person's relationship to you and your care. This form does not address individuals who are involved in the payment to your health care services, such as guarantors.

Patient Name _____
Patient Address _____

By completing this form and signing below, your are granting Trostel Chiropractic, Ltd. Permission to share protected health information (PHI), including without limitation, appointment information, test results, diagnosis, or treatment plans, with the individual(s) listed below who is/are a family member, close friend, or other person involved in your care. Under certain medical circumstances, however, a licensed healthcare professional may identify one or more individuals after individuals after determining in his/her professional judgment that sharing PHI on a continual basis would be in your best interest (e.g. emergency situations, patient has Alzheimer's and no power of attorney was granted to the caregiver etc.) There may be other medical situations where we may disclose PHI to family members or friends in accordance with federal or state law. Categories of people will not be accepted (e.g. "all family members" or "all members of church" because of the difficulty in verifying their identity.

Name	Relationship	Address & Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____

Patient Signature (required) _____ **Date** _____

Staff Signature (if applicable) _____ **Date** _____

Patient Consent Form

Trostel Chiropractic, Ltd.
2487 N. Monroe St.
Decatur, IL 62526
(217) 872-5452

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third – party payers.
- Conduct normal healthcare operations such as quality assessments and physicians certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care options. I also understand you are not required to agree to my requested restrictions, but if you do not agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this content.

Patient Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____

LOW BACK PAIN AND DISABILITY QUESTIONNAIRE (Revised Oswerstry)

Patient Name:_____ Date:_____ Acct#:_____

This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage everyday life. Please answer every section and mark in each section only the ONE box that applies to you. We realize you may consider that two of the statements in any one section relate to you, but please just mark the box that most closely describes your problem.

Pain Intensity:
[ ] The pain comes and goes and is very mild.
[ ] The pain is mild and does not vary much.
[ ] The pain comes and goes and is moderate.
[ ] The pain is moderate and does not vary much.
[ ] The pain comes and goes and is very severe.
[ ] The pain is severe and does not vary much .

Personal Care:
[ ] I would not have to change my way of washing or dressing in order to avoid pain.
[ ] I do not normally change my way of washing or dressing even though it causes some pain.
[ ] Washing and dressing increase the pain but I manage not to change my way of doing it.
[ ] Washing and dressing increase the pain and I find it necessary to change my way of doing it.
[ ] Because of the pain i am unable to do some washing and dressing without help
[ ] Because of the pain I am unable to do any washing and dressing without help.

Lifting:
[ ] I can lift heavy weights without extra pain.
[ ] I can lift heavy weights but it causes extra pain.
[ ] Pain prevents me from lifting heavy weights off the floor.
[ ] Pain prevents me from lifting heavy weights off the floor, but I manage if they are conveniently positioned.
[ ] Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
[ ] I can only lift light weights at the most.

Walking:
[ ] Pain does not prevent me from walking any distance
[ ] Pain prevents me from walking more than 1 mile
[ ] Pain prevents me from walking more than 1/2 mile
[ ] Pain prevents me from walking more that 1/4 mile
[ ] I cannot walk without a cane or crutches.
[ ] I am in bed most of the time and have to crawl to the toilet.

Sitting:
[ ] I can sit in any chair as long as I like.
[ ] I can only sit in my favorite chair as long as I like.
[ ] Pain prevents me from sitting more than 1 hour.
[ ] Pain prevents me form sitting more than 1/2 hour.
[ ] Pain prevents me from sitting more than 10 minutes.
[ ] Pain prevents me from sitting at all

Standing:
[ ] I can stand as long as I want without pain.
[ ] I have some pain on standing but it does not increase with time.
[ ] I cannot stand for longer than one hour without increasing pain.
[ ] I cannot stand for longer than 1/2 hour without increasing pain.
[ ] I cannot stand for longer than 10 minutes without increasing pain.
[ ] I avoid standing because it increases the pain straight away.

Sleeping:
[ ] I get no pain in bed.
[ ] I get pain in bed but it does not prevent me from sleeping well.
[ ] Because of pain my normal night's sleep is reduced by less than 1/4.
[ ] Because of pain my normal night's sleep is reduced by less than 1/2.
[ ] Because of my pain my normal night's sleep is reduced by less than 3/4.
[ ] Pain prevents me from sleeping at all.

Social Life:
[ ] My social life is normal and gives me no pain.
[ ] My social life is normal but increases the degree of pain.
[ ] Pain has no significant effect on my social lift apart from limiting my more energetic interests, e.g., dancing, Etc.
[ ] Pain has restricted my social life and I do not go out very often.
[ ] Pain has restricted my social life to my home.
[ ] I have hardly any social life because of the pain.

Travelling:
[ ] I get no Pain while travelling.
[ ] I get some pain whilst travelling but none of my usual forms of travel make it any worse.
[ ] I get extra pain whilst travelling but it does not compel me to seek alternative forms of travel.
[ ] I get extra pain whilst travelling which compels me to seek alternative forms of travel.
[ ] Pain restricts all forms of travel.
[ ] Pain prevents all forms of travel except that done lying down.

Changing Degree of Pain:
[ ] My pain is rapidly getting better.
[ ] My pain fluctuates but overall is definitely getting better.
[ ] My pain seems to be getting better but improvement is slow at present.
[ ] My pain is neither getting better nor worse.
[ ] My pain is gradually worsening
[ ] My pain is rapidly worsening.

Patient Name _____ Date _____

NECK DISABILITY INDEX

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage in everyday life. Please answer every section and mark in each section only the ONE box which applies to you. We realize you may consider that two of the statements in any one section relate to you, but please just mark the box which most closely describes your problem.

'ain Intensity

- ☐ I have no pain at the moment.
- ☐ The pain is very mild at the moment.
- ☐ The pain is moderate at the moment.
- ☐ The pain is fairly severe at the moment.
- ☐ The pain is very severe at the moment.
- ☐ The pain is the worst imaginable at the moment.

Personal Care (Washing, Dressing, etc.)

- ☐ I can look after myself normally without causing extra pain.
- ☐ I can look after myself normally but it causes extra pain.
- ☐ It is painful to look after myself and I am slow and careful.
- ☐ I need some help but manage most of my personal care.
- ☐ I do not get dressed, I wash with difficulty and stay in bed.

Lifting

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it gives extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table.
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can lift very light weights.
- ☐ I cannot lift or carry anything at all.

Reading

- I can read as much as I want to with no pain in my neck.
- ☐ I can read as much as I want to with slight pain in my neck.
- ☐ I can read as much as I want with moderate pain in my neck.
- ☐ I can't read as much as I want because of moderate pain in my neck.
- ☐ I can hardly read at all because of severe pain in my neck.
- ☐ I cannot read at all.

Headaches

- ☐ I have no headaches at all.
- ☐ I have slight headaches with come in-frequently.
- ☐ I have moderate headaches which come in-frequently.
- ☐ I have moderate headaches which come frequently.
- ☐ I have severe headaches which come frequently.
- ☐ I have headaches almost all the time.

Concentration

- ☐ I can concentrate fully when I want to with no no difficulty.
- ☐ I can concentrate fully when I want to with slight difficulty.
- ☐ I have a fair degree of difficulty in concentrating when I want to.
- ☐ I have a lot of difficulty in concentrating when I want to.
- ☐ I have a great deal of difficulty in concentrating when I want to.
- ☐ I cannot concentrate at all.

Work

- ☐ I can do as much work as I want to.
- ☐ I can only do my usual work, but no more.
- ☐ I can do most of my usual work, but no more.
- ☐ I cannot do my usual work.
- ☐ I can hardly do any work at all.
- ☐ I can't do any work at all.

Driving

- ☐ I can drive my car without any neck pain.
- ☐ I can drive my car as long as I want the slight Pain in my neck.
- ☐ I can drive my car as long as I want with Moderate pain in my neck.
- ☐ I can't drive my car as long as I want because Of moderate pain in my neck.
- ☐ I can hardly drive at all because of severe pain In my neck.
- ☐ I can't drive my car at all.

Sleeping (Sleepless)

- ☐ I have no trouble sleeping.
- ☐ My sleep is slightly disturbed (Less than 1hr.)
- ☐ My sleep is mildly disturbed. (1-2 hr)
- ☐ My sleep is moderately disturbed. (2-3 hr)
- ☐ My sleep is greatly disturbed (3-5 hr)
- ☐ My sleep is completely disturbed. (5-7 hr)

Recreation

- ☐ I am able to engage in all my recreation activities with no neck pain at
- ☐ I am able to engage in all my recreation activities, with some pain in my neck.
- ☐ I am able to engage in most, but not all of my usual recreation activities because of pain in my neck.
- ☐ I am able to engage in a few of my usual recreation activities because of pain in my neck.
- ☐ I can hardly do any recreation activities because of pain in my neck.
- ☐ I can't do any recreation activities at all.

Pain Severity Scale: Rate the Severity of your pain by checking one box on the following scale.

No Pain

0	1	2	3	4	5	6	7	8	9	10

Excruciating Pain

Patient name: Date:

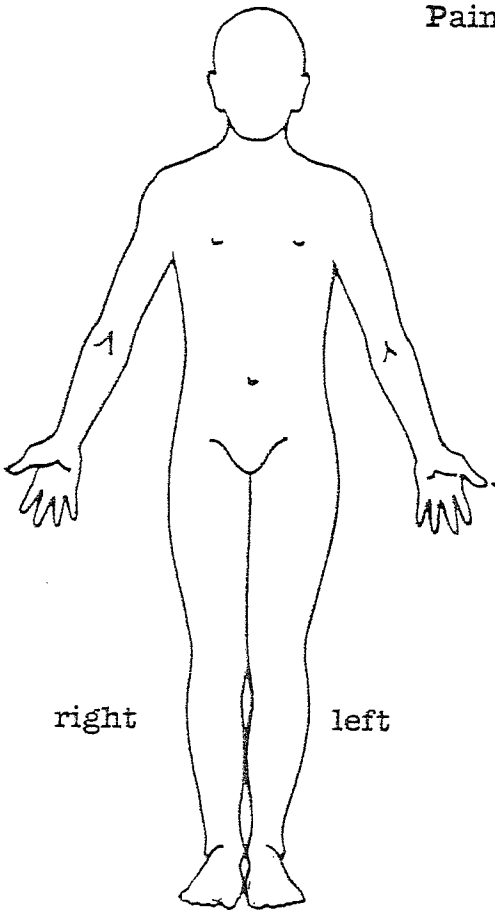
SHOW AREA(S) OF PAIN OR UNUSUAL FEELING

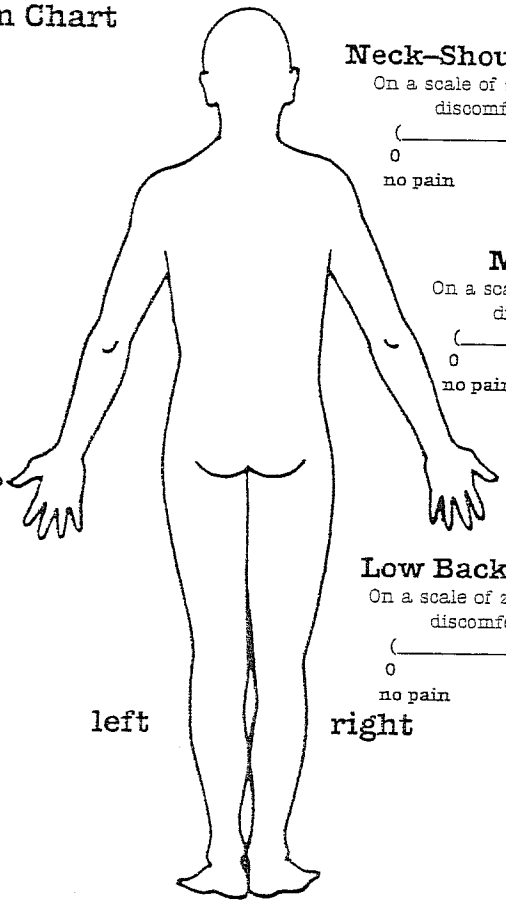
Mark the areas on this body where you feel the described sensations.
Use the appropriate symbols.
Mark areas of radiation.
Include all affected areas.

Numbness	Pins & Needles	Burning	Aching	Stabbing
- - - - -	OOOOO	XXXXX	*****	/////
- - - - -	OOOOO	XXXXX	*****	/////
- - - - -	OOOOO	XXXXX	*****	/////

Please mark on the pain scale from Zero to 10 the pain you feel with this condition. 10 being the worst pain you have felt with this condition.

Pain Chart





Neck–Shoulder–Arm Pain
On a scale of zero to 10, I rate my discomfort as follows:
0 — 10
no pain — severe pain

Mid Back Pain
On a scale of zero to 10, I rate my discomfort as follows:
0 — 10
no pain — severe pain

Low Back and Leg Pain
On a scale of zero to 10, I rate my discomfort as follows:
0 — 10
no pain — severe pain

Date:_____

_____
Signature

Medical doctors, chiropractic doctors, osteopaths, and physical therapists who perform manipulation are required by law to obtain your informed consent before starting treatment.

I_____, of_____
do hereby give my consent to the performance of conservative noninvasive treatment to the joints and soft tissues. I understand that the procedures may consist of manipulations/adjustments involving movement of the joints and soft tissues. Physical therapy and exercises may also be used.

Although spinal manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware that there are possible risks and complications associated with these procedures as follows:

Soreness: I am aware that like exercise it is common to experience muscle soreness in the first few treatments.

Dizziness: Temporary symptoms like dizziness and nausea can occur but are relatively rare.

Fractures/Joint Injury: I further understand that in isolated cases underlying physical defects, deformities or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disk, or other abnormality is detected, this office will proceed with extra caution.

Stroke: Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are rare. I am aware that nerve or brain damage including stroke is reported to occur once in one million to once in ten million treatments. Once in a million is about the same chance as getting hit by lightning. Once in ten million is about the same chance as

a normal dose of aspirin or Tylenol causing death.

Physical Therapy Burns: Some of the therapies used in this office generate heat and may rarely cause a burn. Despite precautions, if a burn is obtained, there will be a temporary increase of pain and possible blistering. This should be reported to the doctor.

Tests have been performed on me to minimize the risk of any complication from treatment and I freely assume these risks.

TREATMENT RESULTS

I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits.

I realize that the practice of medicine, including chiropractic, is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures.

I agree to the performance of these procedures by my doctor and such other persons of the doctor's choosing.

ALTERNATIVE TREATMENTS AVAILABLE

Reasonable alternatives to these procedures have been explained to me including rest, home applications of therapy, prescription or over-the-counter medications, exercises and possible surgery.

Medications: Medication can be used to reduce pain or inflammation. I am aware that long-term use or overuse of medication is always a cause for

concern. Drugs may mask pathology, produce inadequate or short-term relief, undesirable side-effects, physical or psychological dependence, and may have to be continued indefinitely. Some medications may involve serious risks.

Rest/Exercise: It has been explained to me that simple rest is not likely to reverse pathology, although it may temporarily reduce inflammation and pain. The same is true of ice, heat, or other home therapy. Prolonged bedrest contributes to weakened bones and joint stiffness. Exercises are of limited value but are not corrective of injured nerve and joint tissues.

Surgery: Surgery may be necessary for joint instability or serious disk rupture. Surgical risks may include unsuccessful outcome, complications, pain or reaction to anesthesia, and prolonged recovery.

Nontreatment: I understand the potential risks of refusing or neglecting care may include increased pain, scar/adhesion formation, restricted motion, possible nerve damage, increased inflammation, and worsening pathology. The aforementioned may complicate treatment making future recovery and rehabilitation more difficult and lengthy.

I have read or have had read to me the above explanation of chiropractic treatment. Any questions I have had regarding these procedures have been answered to my satisfaction PRIOR TO MY SIGNING THIS CONSENT FORM. I have made my decision voluntarily and freely.

To attest to my consent to these procedures, I hereby affix my signature to this authorization for treatment.

_____Signature of patient

_____Signature of witness

_____Date and time

Trostel Chiropractic Ltd.
2487 N. Monroe St.
Decatur, IL 62526
(217) 872-5452

LEGAL ASSIGNMENTOF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

Primary Insurance Company_____
Secondary Insurance Company_____

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee heal care benefits coverage with the above captioned, and herby assign and convey directly to Dr. Leanne C. Trostel medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor or clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I herby authorize the doctor to release all medical information necessary to process this claim. I herby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claims, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinics expense.

I further authorize Dr. Leanne C. Trostel's staff to perform such services deemed necessary to treat my condition(s). I understand that I am fully responsible for all charges that may include legal fees, collection fees, or other expenses incurred by the provider in collection my account.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

Signature _____ Date _____