Madison Heights Chiropractic Center

SLIP AND FALL INTAKE & HISTORY FORM

(NEW PATIENT ONLY)

Patient Name_____ Male____ Female____ Other____
(last) (first) (middle initial)

Address_____City_____State_____Zip_____

Email_____
(Email is required for Patient Portal Access)

Cell Phone_____ Home Phone_____ **Are you Pregnant? YES NO Unsure**

Date of Birth_____ Age_____
(month) (day) (year)

Single ____ Married ____ Separated ____ Divorced ____ Widowed ____ Number of Children _____

Name of Spouse_____ Name of Children_____

Patient's Occupation or Profession_____

Employed by_____ Business Phone_____

Is the above patient under the age of 18? ___ No ___ Yes If Yes, Parent/Guardian please complete line below:

Name_____ Relationship_____ SSN#_____

Address _____ Phone _____

Primary Care Physician (PCP) Name _____ Phone Number _____

Date of your last visit with your PCP & Yearly Physical:_____

Past Surgeries_____
_____

How did you hear about our office? **Referred by** _____

Have you had an X-Ray/MRI/CT (circle) done **AFTER** the accident? YES / NO Where? Neck Mid-Back Low Back
Have you had chiropractic before?_____Where?_____
Have you had Pain Management: _____ Current _____ Previous _____ Never

Do you have additional health insurance? No Yes If yes:_____ Policy# _____
Do you have any of the following(circle): HSA FSA None

Insurance Company Name: _____
Agent/Adjuster's Name: _____ Claim# _____
Date your Accident Occurred: _____ City/State:_____

HAVE YOU EXPERIENCED ANY OF THE FOLLOWING BEFORE THE ACCIDENT? IF YES, MARK "X

(This applies to symptoms that you have experienced in the past, from birth to BEFORE the accident)

( ) Acid Reflux/Heartburn
( ) Allergies
( ) Arthritis
( ) Asthma
( ) Base of Neck Pain
( ) *Balance/Coordination Problems*
( ) Bladder Troubles
( ) *Bleeding Disorders*
( ) *Blood in Urine or Stool*
( ) Breast Implants
( ) *Bruising Easily*
( ) Bulging Disc
( ) Bypass Surgery
( ) Cancer
( ) Chest Pain
( ) *Chronic Lung Disease*
( ) Clicking or Grinding in Neck
( ) Cluster Headaches
( ) Cold Feet
( ) Constipation
( ) Cool Hands
( ) Depression
( ) Diarrhea
( ) *Dizziness*
( ) Double Vision
( ) Drop Attack
( ) Ear Infections
( ) *Ehlers-Danlos (Type IV)*
( ) Fatigue
( ) Frequent Urination
( ) *Fibromuscular Dystrophy*
( ) Gall Bladder Trouble
( ) Head Feels Heavy
( ) Headaches
( ) Heart Attack
( ) Heart Problems
( ) Heart Trouble
( ) Herniated Disc
( ) Hip Pain
( ) *Hypertension/HBP*
( ) *Lightheadedness*
( ) Indigestion
( ) Inner Tension
( ) Intestinal Gas
( ) Irritability
( ) Jaw Pain
( ) Kidney Trouble
( ) Knots in the Back Muscle
( ) Light Bother Eyes
( ) Loss of Balance
( ) Low Back Pain
( ) Lower Mid Back Pain
( ) *Marfans*
( ) Menstrual Cramps and Pain
( ) Menstrual irregularity
( ) Mid Back Pain
( ) Mid Back Pain when Sleeping
( ) Migraines
( ) Muscle Spasms in Mid/Low Back
( ) Muscle Spasms in Neck
( ) Nausea or Upset Stomach
( ) Neck Pain
( ) *Numbness/Weakness of head or face*
( ) Numbness of Arm or Hand
( ) Numbness of Legs or Feet
( ) *Nystagmus/Rapid Eye Mov't*
( ) Pain in Shoulder Blades
( ) Pain into feet
( ) Pain into Legs
( ) Pain into the Buttock
( ) Painful Joints
( ) Pinched Nerve
( ) Pins and Needles in Arms/Hands
( ) Pins and Needles in Back/Legs/Feet
( ) *Polycystic Kidney Disease*
( ) Poor Circulation
( ) Postmenopausal
( ) Ringing in Ears
( ) Sciatic Pain
( ) Sexual Dysfunction
( ) Shooting Head Pain
( ) Shoulder Pain
( ) Shoulder Tightness
( ) Sinus Trouble
( ) Snoring
( ) Stiff Mid Back
( ) Stiff Neck
( ) Stomach Disorder
( ) *Strokes*
( ) Swollen Joints
( ) Throbbing Head Pain
( ) Thyroid Trouble
( ) Tingling in Fingers
( ) Trouble Bending
( ) Trouble Sleeping
( ) *Trouble Speaking (Speech)*
( ) *Trouble Swallowing*
( ) Trouble Twisting
( ) Ulcers
( ) Upper Back Pain
( ) *Upper Respiratory Infection*
( ) *Urinary Tract Infections*
( ) Vascular Disease
( ) *Vision problems*

Personal History: (circle all conditions that apply)
Anemia, Arthritis, Arteriosclerosis (hardening/thickening of artery walls), Asthma, Cancer: _____, Cardiovascular Problems (Circulation issues, Swelling, etc), Congestive Heart Failure, COPD, COVID, Crohn's, Depression, Diabetes, Dizziness/Fainting, Headaches, Heart Disease, Heart Attack, Heart Problems, Hepatitis, HIV, High Blood Pressure, Hypertension, Irritable Bowel Syndrome, Kidney Problems, Liver Disease, Low Blood Pressure, Osteoporosis, Pacemaker, Respiratory Problems, Rheumatoid Arthritis, Seizures, Stroke,Systemic Disease, Tuberculosis, Thyroid Problems, Other:_____

***Have you received the COVID19 Vaccine? ___ No ___ Yes. Have you had the COVID virus? ___ No ___ Yes**
(This question MUST be answered for our records)

Have you ever experienced in your lifetime any of the following: (circle all that apply)
Back Problems Sciatica Disc Disease Neck Problems Headaches None

In the past (at any time in your lifetime) have you had any: (circle all that apply)
Car Accidents Falls Work Injuries Sports Injuries None

Family History:
Has your mother had any of the above conditions? YES / NO, IF Yes, list conditions? _____
Is your mother deceased? YES / NO
Has your father had any of the above conditions? YES / NO, IF Yes, list conditions? _____
Is your father deceased? YES / NO
Have your grandparents, sister, brother had any of the above conditions? YES / NO, IF Yes, list conditions?_____
_____

Social History:
Do you drink alcohol? Yes / No If Yes, How Many? 1-2 3-4 5+ How Often? Daily Weekly Monthly Occasional/Social
Do you (circle one) smoke/vape tobacco? Never Former smoker Occasional/social (Light) Current (Daily) Smokeless tobacco
Do you (circle one) smoke / vape: Marijuana THC CBD Other:_____
Do you use (circle): THC / CBD products
Have you used illegal drugs? Yes / No
Do you exercise? YES / No, If Yes Circle one: Daily Weekly Monthly
If Yes, What Kind? Yoga/Pilates Weight Training Running/Jogging Other: _____

What are your Condition(s) / Areas of Pain?
When did the pain / condition(s) start? unknown ____ or date:_____ How long have you experienced this?
What is your pain scale today? 0 1 2 3 4 5 6 7 8 9 10 **No Pain**_____**Worst Pain**
Have you had the problem previously? YES NO, If Yes how long ago?
Have you been treated for other pain / conditions that are not currently the primary problem?
What previous treatment(s) have you had?
What are you doing for it now?
What have you found to be effective?
Are you seeing another doctor for any reason, including pregnancy? YES NO **If Yes, please explain:**
What medications and/or supplements are you currently taking? (if not already provided)

Accident Questionnaire:
Part 1:

		Yes	No	Unsure
1.	Did you strike your head in the accident?			
2.	Do you have a clear recollection of the accident and/or events before and following the accident: (*If the answer is No, please answer 2a.)*			
2.a	Did you have a loss of consciousness (you blacked out for a few seconds or longer), If Yes, please answer 2b.			
2.b	How long did you lose consciousness for? _____			
3.	Have you experienced headaches since the accident?			
4.	Have you experienced dizziness since the accident?			
5.	Have you experienced nausea and/or vomiting at the scene of the accident?			
6.	Have you experienced blurred vision?			
7.	Have you experienced Ringing in the ears?			
8.	Have you experienced excessive fatigue; physical and/or mental?			
9.	Have you experienced confusion or disorientation (forgetfulness)?			
10.	Have you experienced memory problems (i.e. go into the kitchen & forget why)?			
11.	Have you experienced concentration issues?			
12.	Bothered by noise since the accident?			

13.	Have you experienced a temperament (mood) change?			
14.	Have you experienced a change in your sleep pattern?			
15.	Have you experienced balance issues?			
16.	Do you think more slowly than before the accident?			
17.	Do you experience difficulty reasoning and solving problems?			
18.	Have you experienced restlessness?			
19.	Have you experienced problems reading or listening since the accident?			
20.	Have you had problems paying attention since the accident?			
21.	Have you experienced issues with your attention span (distractibility)?			
22.	Have your math abilities been affected?			
23.	Have you experienced sexual dysfunction since the accident?			
24.	Have you experienced speech problems? (searching for words)			
25.	Has your diction been affected? (the choice and use of words)			

Part 2:

		No	Mild	Moderate	Severe
1.	Have you experienced depression since the accident?				
2.	Have you experienced anxiety since the accident?				
3.	Have you experienced a low frustration tolerance since the accident?				
4.	Have you experienced apathy (lack of interest) since the accident?				
5.	Have you experienced withdrawal from friends since the accident?				
6.	Have you experienced withdrawal from other social activities since the accident?				
7.	Have you experienced nightmares concerning the accident?				
8.	Have you experienced irritability and/or rages since the accident?				
9.	Have you experienced nervousness since the accident?				
10.	Have you experienced crying spells since the accident?				
11.	Have you experienced a lowered self-esteem since the accident?				

Part 3:

Did you hit any part of your body during the fall, for example, head on the ground, etc?
(circle one) YES NO UNSURE

If yes, which part and how?_____
_____

Where were you taken after the accident? (circle) Hospital / Urgent Care / Friends House / Parents House / Home
Other: _____

How did you get to the destination you were taken to? (circle)
Ambulance / Someone drove me / I drove myself / Other:_____

Were you hospitalized (stayed overnight)? (circle) YES NO Other:_____

If YES, for how long did you stay? _____

Did you receive care from a health care specialist? (circle) YES NO Other: _____

If YES, when did you receive care? (circle)
Immediately after the accident / a few days / a week / a few weeks / a month / Other:_____

If you received care from a health care specialist, what was their name?
_____ or I don't remember

What type of care were you given? Pain Medication / Muscle Relaxers / Other: _____

How long did you receive care for? Care is still ongoing / Care is no longer occurring / Other:_____

Does it bother you to be in the area of the accident? YES / NO / SOMETIMES

State any strange events that happened during or immediately after the accident_____
_____
_____
_____

Have you had any time loss from work? YES / NO If yes, for how long? _____

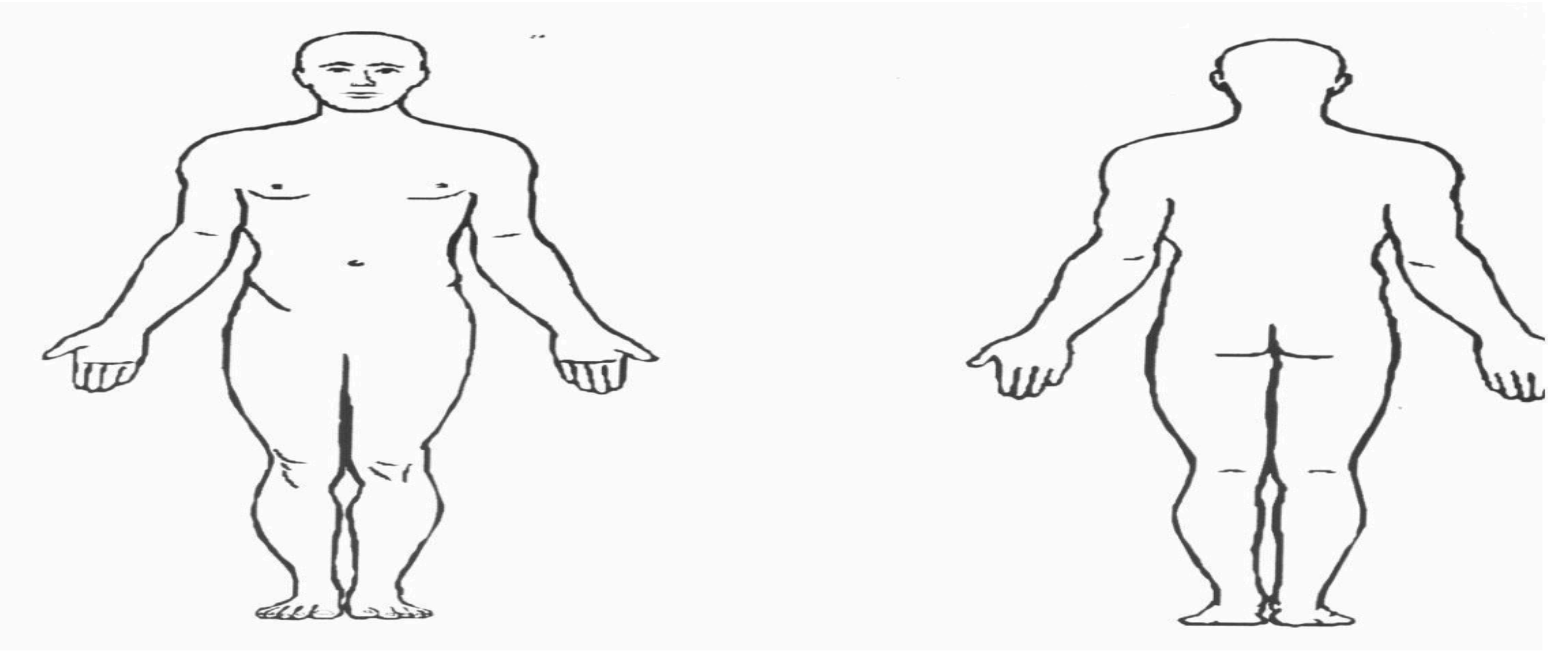
Have you had any outside help since the accident? YES / NO

If yes, what kind of help did you require after the accident? _____
_____
_____

PLEASE DRAW THE ACCIDENT

MARK PAIN AREA

+++	Burning	000	Stabbing
- - -	Sharp	I I I	Constant



Low Back Disability Questionnaire

Please Read: This questionnaire is designed to enable us to understand how much your low back has affected your ability to manage everyday activities. Please **answer each section by checking the ONE CHOICE that most applies to you**. We realize that you may feel that more than one statement may relate to you, but **please** just check the one choice which closely describes your problem right now.

Section 1 - Pain Intensity
___ A. Tolerates without pain meds.
___ B. No pain meds but pain is bad.
___ C. Pain meds give complete relief.
___ D. Pain meds give moderate relief.
___ E. Pain meds give little relief.
___ F. Pain meds have no effect on pain.

Section 2 - Personal Care
___ A. I can look after myself without extra pain.
___ B. I can look after myself with extra pain.
___ C. It is painful to look after myself, but I must move slowly and carefully.
___ D. I need some help, but I can manage most care.
___ E. I need help everyday in most aspects of care.
___ F. I need help in all aspects of personal care.

Section 3 - Lifting/Carrying
___ A. I can lift/carry heavy (up to 50lbs) items with no pain
___ B. I can lift/carry heavy (up to 50lbs) items, but I have pain
___ C. I can only lift/carry heavy (up to 50lbs) but I cannot bend down to pick it up. It must be table height.
___ D. I can only lift light (up to 20lbs) items from the table.
___ E. I can only lift very light (under 10lbs) items from the table.
___ F. I cannot lift or carry anything

Section 4 - Walking
___ A. Pain does not prevent me from walking.
___ B. I cannot walk more than 1 mile or 30 mins without pain.
___ C. I cannot walk more than ½ mile or 15 mins without pain.
___ D. I cannot walk more than ¼ mile or 10 mins without pain.
___ E. I can walk but with assistance only (ie. cane, crutches, walker, etc.)
___ F. I cannot walk and need a wheelchair and/or I have to crawl to the toilet.

Section 5 - Sitting
___ A. I can sit in any chair as long as I want to.
___ B. I can sit only in specific chairs as long as I want to.
___ C. I can only sit in a specific chair for no more than 1 hour.
___ D. I can only sit in a specific chair for no more than ½ hour.
___ E. I can only sit in a specific chair for no more than 10 mins.
___ F. I cannot sit at all due to the pain.

Section 6 - Standing
___ A. I can stand as long as I want to.
___ B. I can stand, but I have some pain but it doesn't increase with time.
___ C. I cannot stand for more than 1 hour.
___ D. I cannot stand for more than ½ hour.
___ E. I cannot stand for more than 10 minutes.
___ F. I cannot stand at all due to the pain.

Section 7 - Sleeping
___ A. I have no pain in bed.
___ B. I get pain in bed, but I sleep well through the night.
___ C. I get to sleep, but it is reduced by a ¼ of my usual time.
___ D. I get to sleep, but it is reduced by ½ of my usual time.
___ E. I get to sleep, but it is reduced by a ¾ of my usual time.
___ F. I cannot get any sleep due to the pain.

Section 8 - Traveling
___ A. I can travel without pain.
___ B. Travel causes some pain, but does not make it worse.
___ C. Travel causes extra pain but I don't need to change how I travel.
___ D. Travel causes extra pain and I need to change how I travel.
___ E. The pain restricts all travel except lying down.
___ F. The pain restricts all forms of travel.

Section 9 - Social Life
___ A. Normal and causes no pain.
___ B. Normal but causes extra pain.
___ C. The pain limits my energetic interests.
___ D. The pain reduces how often I go out of the house.
___ E. The pain restricts my social life to staying home.
___ F. The pain restricts all forms of social life.

Section 10 - Changing Degree of Pain
___ A. The pain is rapidly improving.
___ B. Pain fluctuates but is improving.
___ C. Improvements are slow but steady.
___ D. Pain is unchanged.
___ E. Pain is gradually worsening.
___ F. Pain is rapidly worsening.

Patient Signature: _____

Neck Disability Questionnaire

Please Read: This questionnaire is designed to enable us to understand how much your low back has affected your ability to manage everyday activities. Please **answer each section by checking the ONE CHOICE that most applies to you**. We realize that you may feel that more than one statement may relate to you, but **please** just check the one choice which closely describes your problem right now.

Section 1 - Pain Intensity
___ A. Tolerates without pain meds.
___ B. No pain meds but pain is bad.
___ C. Pain meds give complete relief.
___ D. Pain meds give moderate relief.
___ E. Pain meds give little relief.
___ F. Pain meds have no effect on pain.

Section 2 - Personal Care
___ A. I can look after myself without extra pain.
___ B. I can look after myself with extra pain.
___ C. It is painful to look after myself, but I must move slowly and carefully.
___ D. I need some help, but I can manage most care.
___ E. I need help everyday in most aspects of care.
___ F. I need help in all aspects of personal care.

Section 3 - Lifting/Carrying
___ A. I can lift/carry heavy (up to 50lbs) items with no pain
___ B. I can lift/carry heavy (up to 50lbs) items, but I have pain
___ C. I can only lift/carry heavy (up to 50lbs) but I cannot bend down to pick it up. It must be table height.
___ D. I can only lift light (up to 20lbs) items from the table.
___ E. I can only lift very light (under 10lbs) items from the table.
___ F. I cannot lift or carry anything

Section 4 - Reading/Looking Downward
___ A. No pain while reading/looking down.
___ B. I have slight pain while reading/looking down.
___ C. I have moderate pain while reading/looking downward.
___ D. I have moderate pain that prevents me from reading/looking downward.
___ E. I have severe pain that prevents me from reading/looking downward.
___ F. I cannot read or look downward at all.

Section 5 - Headaches
___ A. I have no headaches.
___ B. I experience slight, infrequent headaches.
___ C. I experience moderate, infrequent headaches.
___ D. I experience moderate, frequent headaches.
___ E. I experience severe, frequent headaches.
___ F. I experience constant headaches.

Section 6 - Concentration
___ A. I can concentrate without difficulty.
___ B. I can concentrate with slight difficulty.
___ C. I can concentrate with fair difficulty.
___ D. I can concentrate with a lot of difficulty.
___ E. I can concentrate with a lot of difficulty.
___ F. I cannot concentrate at all.

Section 7 - Work
___ A. Work is unrestricted.
___ B. I can perform my usual work load but nothing more.
___ C. I can perform most of my work load but not all of it.
___ D. I cannot perform my usual work load.
___ E. I can hardly do any of my work.
___ F. I cannot work at all.

Section 8 - Traveling/Driving
___ A. I can travel without pain.
___ B. Travel causes some pain, but does not make it worse.
___ C. Travel causes extra pain but I don't need to change how I travel.
___ D. Travel causes extra pain and I need to change how I travel.
___ E. The pain restricts all travel except lying down.
___ F. The pain restricts all forms of travel.

Section 9 - Sleeping
___ A. I have no pain in bed when trying to sleep.
___ B. I get pain in bed, but I sleep well through the night.
___ C. I get to sleep, but it is reduced by a ¼ of my usual time.
___ D. I get to sleep, but it is reduced by ½ of my usual time.
___ E. I get to sleep, but it is reduced by a ¾ of my usual time.
___ F. I cannot get any sleep due to the pain.

Section 10 - Recreation/Social Life
___ A. Normal and causes no pain.
___ B. Normal but causes extra pain.
___ C. The pain limits my activity.
___ D. The pain reduces how often I go out of the house.
___ E. The pain restricts my social life to staying home.
___ F. The pain restricts all forms of social life.

Patient Signature: _____

General Pain Index Questionnaire

Please mark how much your pain presently **prevents** you from doing what you would normally do. Regarding each category, please indicate the **overall** impact your present pain has on your life, not just when the pain is at its worst. Please **circle the number** which best describes how your typical level of pain affects these six categories of activities.

1. **Family at home responsibilities:** such as yard work, chores around the house or driving the kids to school

0 1 2 3 4 5 6 7 8 9 10

Completely able to function — Totally unable to function

2. **Recreation:** including hobbies, sports or other leisure activities

0 1 2 3 4 5 6 7 8 9 10

Completely able to function — Totally unable to function

3. **Social activities:** including parties, theater, concerts, dining out and attending other social functions

0 1 2 3 4 5 6 7 8 9 10

Completely able to function — Totally unable to function

4. **Employment:** including volunteer work and homemaking tasks

0 1 2 3 4 5 6 7 8 9 10

Completely able to function — Totally unable to function

5. **Self-care:** such as taking a shower, driving or getting dressed

0 1 2 3 4 5 6 7 8 9 10

Completely able to function — Totally unable to function

6. **Life-support activities:** such as eating and sleeping

0 1 2 3 4 5 6 7 8 9 10

Completely able to function — Totally unable to function

Signature: _____ Date: _____

ACCIDENT & INJURY ASSIGNMENT - AUTHORIZATION OF LIEN

NAME: _____ DATE: _____

I, the assignee, being the patient or legal guardian (for said minor listed below), do hereby irrevocably authorize, direct, assign and give full lien to the office of **MADISON HEIGHTS CHIROPRACTIC CENTER** (located at 28107 John R Rd, Madison Heights, Michigan 48071) hereinafter referred to as the "facility" against any & all insurance benefits, proceeds of any settlement of any settlement, judgment or verdict which may be paid to the undersigned as a result of the injuries or illness for which I have been treated by the facility. I, the assignee further authorize any and all insurance company, case manager, attorney and any & all third party payers to pay directly to the facility **ALL** sums of money due to them for any and all services rendered to me or minor by whom I am responsible for by reason of accident, injury, illness and by any & all reason of any other bills that are due or may become due, and to withhold such sums from any health & accident, workers compensation and or including all insurance or third party benefits. In the event that I retain one or more attorneys who receive(s) proceeds from one of more payers, I hereby direct (and the facility hereby requests) each attorney to provide immediate notice to the facility regarding such proceeds, to promptly pay the facility in-full out of such proceeds a full accounting of such proceeds to the facility. I agree that the purpose of such proceeds shall be primarily to pay my charges. If I have a dispute regarding the charges, any remedies I may have shall not include instructing my attorney to withhold or delay payment of proceeds to the facility. I further agree to and hereby irrevocably waive any present or future right I may have, whether arising under a "common fund doctrine" or other legal basis, to require the facility to absorb the costs associated with, or otherwise assume responsibility for, any portion of my attorney's fees and costs, or other expenses of obtaining proceeds. Assignee agrees that this facility & staff may process medical reports, deliver medical records, consultations, depositions and/or court appearances which must be paid in full in advance by me, and authorize this facility to release any information pertinent to said health care to any insurance company, adjuster, attorney or legal services bureau to facilitate collections under the terms of this document. Assignee grants the facility a full power of attorney to endorse &/or sign my name on any & all checks for payment of any indebtedness owed this office & assignee.

INFORMED CONSENT

I understand that the facility, its doctors & staff are accepting my case based on examination findings & believe the outlined treatment should produce change and/or improvement. However as with any diagnostic test, procedure, examination or doctor's care a guarantee of improvement or complete recovery cannot be made and it is even possible that no change will occur or I may get worse. I further understand that in the practice of medicine, chiropractic, psychological counseling & physical therapy there are some risks including but not limited to fractures, disc injuries, strokes, dislocations, sprains-sprains, drug interactions & reactions, including cardio-pulmonary arrest, death, and/or other injuries or side effects which cannot be predetermined. I do not expect the doctor/provider to be able to anticipate and explain all risks and/or complications, and I wish to rely on the doctor/provider to exercise judgment during the course of the procedure(s) which the doctor/provider feels at the time is in my best interest. Therefore I give my full consent to the doctor/provider to render treatment on me or the minor for whom I am legally responsible by the health care provider of this facility.

INSURANCE BENEFITS - PAYMENT TERMS & CONDITIONS

1. As a courtesy, the facility will obtain a verification of applicable insurance benefits as they are quoted to us but some third party payers mis-quote benefits, coverage and liability. Our facility & staff are **not** responsible for what a third party payer and/or representative may tell us. Any insurance contractual obligations or arrangements between you and an attorney or third party payer are between you and your insurance carrier and/or the third party payer.

2. Our facility will file initial insurance claims for you. Secondary claim submission and/or additional reports or documents sent for your benefit may result in an additional filing medical report charge which you are responsible to pay.

3. Co-pays, deductibles and all non-covered service charges are your responsibility.

4. All account balances, including automobile and work injury claims must be paid in full within 60 days of treatment. Patients and/or legal guardians are fully responsible for all money owed and such payment is not contingent on any settlement, claim, judgment, or verdict by which they may eventually recover said fee and it is also regardless of any attorney liens or pending settlement(s). If a third party payer fails to pay said balance in full within a 60-day period, the patient must pay the balance in full. Assignee is fully responsible for all money owed this facility for any and all treatment, products & services rendered to the patient or minor shown below.

5. A service charge is computed by a 'periodic rate' of 1 ½% per month - 18% per annum & is added to all balances owed 60+ days. Any balance past due 90 days or more will be submitted to an attorney and/or agency for legal action for which the undersigned agrees to be 100% responsible for all monthly service charges, cost related to but not limited to all collection related expenses, attorney fees, court & filing fees. Returned checks, debt & credit charges made payable to this facility for insufficient funds, stop payments or other reasons of non-payment will be assessed a $50.00 charge.

I acknowledge that I have read or have had read to me and understand all terms and conditions of this accident and injury assignment - authorization of lien as stated on this form and agree to all terms & conditions. A photocopy of this document shall be considered as effective and valid as the original.

_____	_____	_____
Print Name of Patient	Signature (if minor, parent must sign)	Date

Madison Heights Chiropractic Center

IRREVOCABLE ESCROW INSTRUCTION AND AGREEMENT

The undersigned patient (hereinafter "Patient) in order to introduce The **MADISON HEIGHTS CHIROPRACTIC CENTER** located at 28107 John R Rd, Madison Heights, Michigan 48071 (hereinafter the "Provider") to extend credit to the patient, hereby irrevocable instruct my attorney and escrow agent, to pay to Provider the **FULL** amount of any bill for services rendered by the Provider, from the proceeds of my personal injury settlement or award within ten (10) days of receipt by him/her of same, excepting time for any negotiable instrument to clear.

This escrow instruction and agreement is irrevocable by me and is being used to include the Provider to provide continued medical services to me resulting from my accident.

Dated:_____

_____
Patient Signature

_____
Patient Name (Printed)

_____

_____
Patient Address

Understood and agreed to by:

Dated:_____

_____
Provider Name

_____
Provider Signature