University Spine Center

DATE: _____/_____/_____

NAME: _____HOME PHONE: _____

ADDRESS: _____CELL PHONE: _____

CITY: _____STATE: _____ZIP: _____WORK PHONE: _____

DATE OF BIRTH: _____/_____/_____ AGE: _____ SS#_____

SPOUSE NAME: _____DOB: _____/_____/_____ SS#_____

EMERGENCY CONTACT: _____ PHONE #: _____

Work History

Current Employer Name: **_____ Address: _____**

Phone Number: _____ Occupational Description: _____

Email: **_____Height: _____Weight: _____**

Race: □Asian □Black □Hispanic □White □Other □Refuse to Answer

Ethnicity: □Latino □Non-Latino □Refuse to Answer **Language:** □English □Spanish □Other: _____

Phone# at employer to obtain health plan documents for billing purposes only: _____

PHYSICIAN INFORMATION

REFFERRED BY: _____PHONE: _____

PRIMARY DOCTOR: _____PHONE: _____

CARDIOLOGIST: _____PHONE: _____

INSURANCE INFORMATION

PRIMARY INSURANCE: _____ID#_____

SECONDARY INSURANCE: _____ ID#_____

PHARMACY INFORMATION

NAME: _____Town & Street: _____ PHONE: _____

1. Please State the Main Reason You Are Here Today: _____

When did you first notice any symptoms (Date of injury if known)? _____

Where did the injury or illness occur and how? _____

Are your symptoms due to an injury at work? ☐No ☐Yes
Are your symptoms due to a **motor vehicle accident**? ☐No ☐Yes
Have you ever been involved in a motor vehicle accident? ☐No ☐Yes—if yes, please explain:

---

2. Have you received treatment for similar symptoms before visiting this office? ☐No ☐Yes

If yes, please provide name/address of **Physician, Chiropractor, Pain management, or Physical Therapy.**

Name and Address of Doctor: _____Phone: _____
Treatment received: _____Fax: _____

Name and Address of Doctor: _____Phone: _____
Treatment received: _____Fax: _____

Have you had any **Surgeries**? ☐No ☐Yes—If yes, list operations, date, doctor/hospital:

Surgery: Date/Doctor/Hospital: _____
Surgery: Date/Doctor/Hospital: _____

3. Please list all your **Current Medications** (including herbal, vitamins and over the counter medications).

Name of Medicine	Dose	Name of Medicine	Dose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

4. Allergies to medicine or other product (latex, tape, peanuts, etc.)?☐No ☐Yes—if yes, please explain:

5. Alcohol How often? _____ Other Substance abuse. Please describe: _____

□ **Smoker** □**Non-Smoker** □ **Quit Smoking: How long ago? _____**

Please circle one: Everyday / Not every day How many per day? _____

How soon after waking up do you smoke your first cigarette? _____

What do you like to do for fun? (Recreational activities) _____

Please check the following illnesses you have had or have now:

☐ Arthritis _____	☐ Diabetes (Insulin?) _____	☐ Eyes _____	☐ Ear/Nose/Throat _____
☐ Epilepsy _____	☐ Heart Disease _____	☐ Psychiatric _____	☐ Bleeding/Clotting _____
☐ Hypertension _____	☐ Cancer _____	☐ Headaches _____	☐ Lungs _____
☐ Stroke _____	☐ Anemia _____	☐ Bowel Dysfunction _____	☐ Bladder Dysfunction _____
☐ Tuberculosis _____	☐ Asthma/COPD _____	☐ Balance/Dizziness _____	☐ Numbness/Tingling _____
☐ Depression _____	☐ vascular disease _____	☐ Blackouts/Fainting _____	☐ Stomach ulcers _____
☐ Osteoarthritis _____	☐ Rheumatoid Arthritis _____	☐ Lyme _____	☐ Fibromyalgia _____
☐ HIV/AIDS _____	☐ Hepatitis Type _____	☐ others (specify) _____	

Pain diagram

Mark the location of your pain on the body

XXX where you have pain.

OOO where you have numbness.

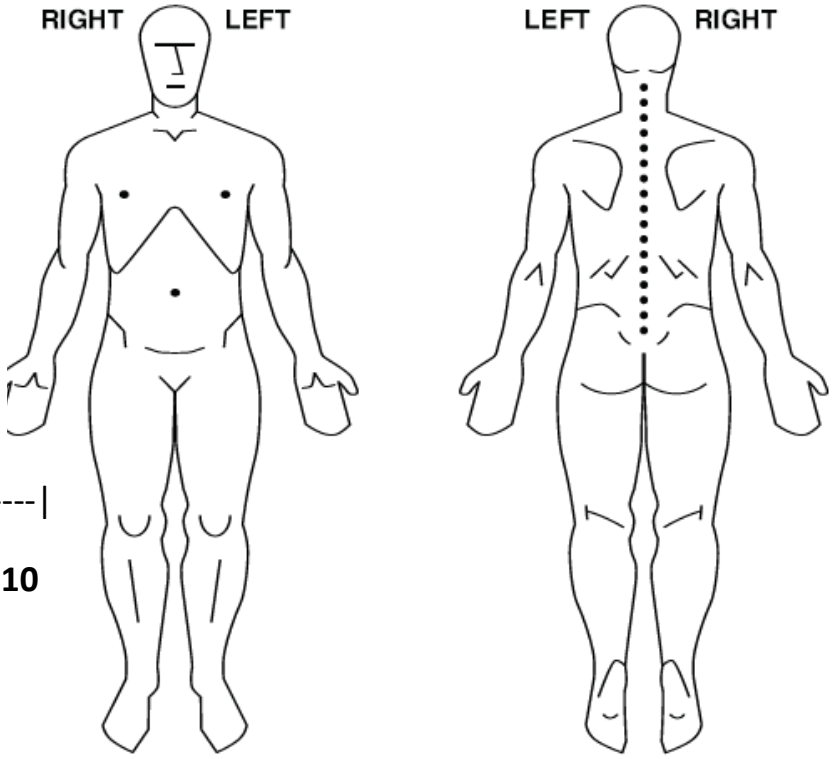
ZZZ where you have weakness.

Mark where your pain is TODAY.

No pain ***Worst***

|----------|----------|

0 1 2 3 4 5 6 7 8 9 10



I have noted any changes made and to the best of my knowledge, I believe all information to be true.

Patient Signature: _____

University Spine Center

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. If you have any questions about this notice, please contact our privacy contact.

This Notice of Privacy Practices advises you about the way we may use and disclose medical information about you. It also describes your rights and certain obligations we have regarding the use and disclosure of your protected health information. We are required to abide by the terms of this notice and may change the terms at any time. Upon you request we will provide you with any revision made to this notice.

Uses and disclosures of Protected Health Information
Your protected health information may be used and disclosed for your ongoing treatment, our ongoing healthcare operations or to secure payment of services.

Treatment
The provision, coordination or management of healthcare and related services among providers or with third party.

Healthcare Operations
Necessary disclosures to run our practice and monitor quality of care including staff performance, evaluation of practice enhancements, and staff education.

Payment
Necessary disclosure to secure reimbursement from you, your insurance company, or other third-party payer for services rendered. In addition, PHI may be disclosed to obtain prior approval from your insurance company to assure payment for services yet to be rendered.

Appointment Confirmation
We will continue our practice of telephone confirmation of all appointments.

Individuals Involved In Your Ongoing Care
Upon you verbal authorization we will disclose your information about you to your designated care givers, other family members, or other individuals.

Case Management for Workers' Compensation/PIP/Disability
We may release PHI for your workers' compensation, auto related or other liability claim, or your claim for disability benefits or similar programs that provide benefits for injuries or illness. This may include claims adjusters, nurse case managers and may be telephonic.

As Required By Law
We will disclose medical information about you when required to do so by federal, state, or local law. This may include activities by the government to monitor the healthcare system and compliance with civil rights laws, audits, inspection and licensor. We may disclose PHI for matters involving public health risks including disease exposure, child abuse or neglect or other domestic abuse, neglect or violence. If you are involved in a lawsuit, we may disclose PHI in response to a subpoena or other court order. PHI may be disclosed to other legal authority pursuant to law enforcement.

Other Uses and Disclosures of Your PHI
Other disclosures of you PHI will be made only upon written authorization and payment of allowable fee. You may obtain an authorization form from our office. You may revoke this authorization at any time in writing. You understand that we are unable to take back any disclosures that have already been made with your prior permission.

Methods of Disclosure
We will respond to your request by mailing copies of your records via US Postal Service. We will not disclose any PHI through e-mail. Under limited circumstances at our discretion your medical records may be faxed.

Your Rights Regarding Your Protected Health Information
Right to Inspect
You have the right to inspect a copy of your PHI including medical and billing information which is used to make decisions about you. You must submit your request in writing. We may charge a fee as permitted by state law for the costs of copying and mailing. We will not fax your medical information to you. We may deny your request under limited circumstances.

Right to Amend
If you feel the medical information, we have is incorrect or incomplete, you may ask us to amend it. We will provide an amendment form which you must complete. You must provide a reason which must support your request. In the absence of a reason we will deny your request.

Rights to an Accounting of Disclosure
We will keep an accounting of all disclosures we made about you. You may request this list in writing and must state a time period no longer than six years and may not include dates before April 14, 2003.

Right to Request Restrictions
You have the right to request a restriction on the medical information we disclose for treatment, payment, operations or your care givers and other involved persons. *We are not required to agree with your request.* We will comply with your request unless the information is needed for

emergency treatment. Your request for limitations must be made in writing and must include what information you want limited and to whom you want these limits to apply.

Changes to this Notice
We reserve the right to change this notice and apply the changes to information we already have about you or may receive in the future. We will post a copy of the current notice in the office. The effective date will appear in the upper right-hand corner. We will offer you a copy of the current notice.

Complaints
If you believe that your rights have been violated, you may file a complaint with our office. Your complaint must be made in writing and addressed to Doranne Moncavage, University Spine Center. No complaints will be acknowledged by phone.

Acknowledgment of Receipt of Privacy Notice

Our notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice and ask questions about our privacy practices. The terms of this notice may change. Upon request a copy of our revised notice will be made available to you. By signing this for you acknowledge that you have received our Notice of Privacy Practices.

Name of Patient: _____Date: _____

✖ Signature of Patient/ Guardian: _____

Please release any information to the following people:

_____

_____

Medicare Authorization

I request that payment of authorized Medicare benefits be made either to me or on behalf to University Spine Center, services furnished to me by University Spine Center. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA 1500 form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charger determination of the Medicare carrier.

✖ Beneficiary Signature: _____ Date: _____

ASSIGNMENT OF BENEFITS

I, _____, irrevocably assign to you, my medical provider, all of my rights and benefits under my insurance contract and/or any employee welfare benefit plan for payment for services rendered to me, including but not limited to all of my rights and benefits under the **Employee Retirement Income Security Act** ("ERISA") applicable to the medical services at issue. I irrevocably authorize you to file insurance claims on my behalf for services rendered to me and this specifically includes filing arbitration/litigation in your name on my behalf against the PIP carrier/health care carrier/employee welfare benefit plan for any and all rights and benefits under ERISA or applicable statute/law, including but not limited to the claim for penalties and fees under ERISA for failure to provide Plan documents and other equitable relief. I irrevocably authorize you to retain an attorney of your choice on my behalf for collection of your bills and/or to file insurance claims on my behalf for services rendered to me. I direct that all reimbursable medical payments go directly to you, my medical provider. I authorize and consent to your acting on my behalf in this regard and in regard to my general health insurance coverage and I specifically authorize you to pursue any administrative appeals conducted pursuant to ERISA.

I authorize you and or your attorney to obtain medical information regarding my physical condition from any other health care provider, including hospitals, diagnostic centers, etc., and I specifically authorize such health care provider(s) to release all such information to you about me, including medical reports, X-ray reports, narrative reports, and any other report or information regarding my physical condition.

If you, my medical provider, initiates a collection proceeding against me, whether through litigation, arbitration or otherwise, in connection with any and all claims unreimbursed and/or under-reimbursed by my insurance carrier, I agree to pay any and all of my medical provider's attorneys' fees and court fees in connection with that proceeding.

Patient Signature: _____Patient name: _____ Date:_____

Effective October 22, 2007

IN-NETWORK

Claims Department/Appeals Department

Insurance: _____Date: _____

Member Name: _____ Member ID# _____

I, _____understand that I am responsible for my in-network out of pocket benefits. My insurance carrier requires University Spine Center to bill me for my in-network responsibility which includes but not limited to, copays, deductibles and co-insurance.

I hereby authorize University Spine Center and their staff as my Designated Representatives to appeal on my behalf concerning services provided by University Spine Center.

Signature of Member: _____

Signature of Designated Representative: _____

Name of Designated Representative: _____

OUT-OF-NETWORK

Claims Department/Appeals Department

Insurance: _____Date: _____

Member Name: _____ Member ID# _____

I, _____understand that I am utilizing my out of network benefits and that my insurance company may send to me, the payment(s) for services by University Spine Center in my treatment. I also understand that by paying a partial payment at the time services are rendered, in no way means the doctors are in network. I understand that the partial payment collected will be posted to my account as a payment towards my co/insurance and or deductible. I agree to sign over the full amount to University Spine Center within thirty days of receipt of the same. If I fail to do so, I understand that in addition to being responsible for the full amount charged by University Spine Center for said services, I will be responsible for any charges incurred by him in pursuing and collecting from me.

I authorize payment of medical benefits for services performed by University Spine Center to be sent directly to:

University Spine Center 504 Valley Road Suite 203 Wayne, NJ 07470

I hereby authorize University Spine Center/Practice Max and their staff as my Designated Representatives to appeal on my behalf

concerning surgical services provided by University Spine Center on date of service _____.

This authorization is valid until appeals are resolved and/or appeal rights are exhausted.

Signature of Member: _____

Signature of Designated Representative: _____

Name of Designated Representative: _____

Oswestry Low Back Pain Disability Questionnaire

Instructions

This questionnaire has been designed to give us information as to how your back or leg pain is affecting your ability to manage in everyday life. Please answer by checking ONE box in each section for the statement which best applies to you. We realize you may consider that two or more statements in any one section apply but please just shade out the spot that indicates the statement which most clearly describes your problems.

Section 1 – Pain 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**

Section 2 – 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 need help every day in most aspects of self-care**
- **I do not get dressed, I wash with difficulty**

Section 3 – 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 placed eg. 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**

Section 4 – Walking*

- **Pain does not prevent me walking any distance**
- **Pain prevents me from walking more than 1 mile**
- **Pain prevents me from walking more than ½ mile**
- **Pain prevents me from walking more than 100 yards**
- **I can only walk using a stick or crutches**
- **I am in bed most of the time**

Section 5 – 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 sitting more than one hour**
- **Pain prevents me from sitting more than 30 minutes**
- **Pain prevents me from sitting more than 10 minutes**
- **Pain prevents me from sitting at all**

Section 6 – Standing

- **I can stand as long as I want without extra pain**
- **I can stand as long as I want but it gives me extra pain**
- **Pain prevents me from standing for more than 1 hour**
- **Pain prevents me from standing for more than 30 minutes**
- **Pain prevents me from standing for more than 10 minutes**
- **Pain prevents me from standing at all**

Section 7 – Sleeping

□ My sleep is never disturbed by pain

□ My sleep is occasionally disturbed by pain

□ Because of pain I have less than 6 hours sleep

□ Because of pain I have less than 4 hours sleep

□ Because of pain I have less than 2 hours sleep

□ Pain prevents me from sleeping at all

Section 8 – Sex life (if applicable)

□ My sex life is normal and causes no extra pain

□ My sex life is normal but causes some extra pain

□ My sex life is nearly normal but is very painful

□ My sex life is severely restricted by pain

□ My sex life is nearly absent because of pain

□ Pain prevents any sex life at all

Section 9 – Social life

□ My social life is normal and gives me no extra pain

□ My social life is normal but increases the degree of pain

□ Pain has no significant effect on my social life apart from limiting my more energetic interests eg, sport

□ Pain has restricted my social life and I do not go out as often

□ Pain has restricted my social life to my home

□ I have no social life because of pain

Section 10 – Travelling

□ I can travel anywhere without pain

□ I can travel anywhere but it gives me extra pain

□ Pain is bad but I manage journeys over two hours

□ Pain restricts me to journeys of less than one hour

□ Pain restricts me to short necessary journeys under 30 minutes

□ Pain prevents me from travelling except to receive treatment

Patient Name: _____ Date:_____

Score: _____

Neck Disability Index

This questionnaire has been designed to give us 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 that applies to you**. We realize you may consider that two or more statements in any one section relate to you, but please just mark the box that most closely describes your problem.

Section 1: Pain 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

Section 2: 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 can manage most of my personal care
- □ I need help every day in most aspects of self care
- □ I do not get dressed, I wash with difficulty and stay in bed

Section 3: Lifting

- □ I can lift heavy weights without extra pain
- □ I can lift heavy weights but it gives extra pain
- □ Pain prevents me lifting heavy weights off the floor, but I can manage if they are conveniently placed, 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 only lift very light weights
- □ I cannot lift or carry anything

Section 4: 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

Section 5: Headaches

- □ I have no headaches at all
- □ I have slight headaches, which come infrequently
- □ I have moderate headaches, which come infrequently
- □ I have moderate headaches, which come frequently
- □ I have severe headaches, which come frequently
- □ I have headaches almost all the time

Section 6: Concentration

□ I can concentrate fully when I want to with 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

Section 7: 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

Section 8: Driving

□ I can drive my car without any neck pain
□ I can drive my car as long as I want with 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

Section 9: Sleeping

□ I have no trouble sleeping
□ My sleep is slightly disturbed (less than 1 hr sleepless)
□ My sleep is mildly disturbed (1-2 hrs sleepless)
□ My sleep is moderately disturbed (2-3 hrs sleepless)
□ My sleep is greatly disturbed (3-5 hrs sleepless)
□ My sleep is completely disturbed (5-7 hrs sleepless)

Section 10: Recreation

□ I am able to engage in all my recreation activities with no neck pain at all
□ 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

Patient Name: _____ Date: _____

Score: _____

New Jersey Department of Banking and Insurance

CONSENT TO REPRESENTATION IN APPEALS OF UTILIZATION MANAGEMENT DETERMINATIONS AND AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS IN UM APPEALS AND INDEPENDENT ARBITRATION OF CLAIMS

APPEALS OF UTILIZATION MANAGEMENT DETERMINATIONS

You have the right to ask your insurer, HMO or other company providing your health benefits (carrier) to change its utilization management (UM) decision if the carrier determines that a service or treatment covered under your health benefits plan is or was not medically necessary.* This is called a UM appeal. You also have the right to allow a doctor, hospital or other health care provider to make a UM appeal for you.

There are three appeal stages if you are covered under a health benefits plan issued in New Jersey. Stage 1: the carrier reviews your case using a different health care professional from the one who first reviewed your case. Stage 2: the carrier reviews your case using a panel that includes medical professionals trained in cases like yours. Stage 3: your case will be reviewed through the Independent Health Care Appeals Program of the New Jersey Department of Banking and Insurance (DOBI) using an Independent Utilization Review Organization (IURO) that contracts with medical professionals whose practices include cases like yours. The health care provider is required to attempt to send you a letter telling you it intends to file an appeal before filing at each stage.

At Stage 3, the health care provider will share your personal and medical information with DOBI, the IURO, and the IURO's contracted medical professionals. Everyone is required by law to keep your information confidential. DOBI must report data about IURO decisions, but no personal information is ever included in these reports.

You have the right to cancel (revoke) your consent at any time. Your financial obligation, IF ANY, does not change because you choose to give consent to representation, or later revoke your consent. Your consent to representation and release of information for appeal of a UM determination will end 24 months after the date you sign the consent.

INDEPENDENT ARBITRATION OF CLAIMS

Your health care provider has the right to take certain claims to an independent claims arbitration process through the DOBI. To arbitrate the claim(s), the health care provider may share some of your personal and medical information with the DOBI, the arbitration organization, and the arbitration professional(s). Everyone is required to keep your information confidential. The DOBI reports data about the arbitration outcomes, but no personal information will be in the reports. Your consent to the release of information for the arbitration process will end 24 months after the date you sign the consent.

CONSENT TO REPRESENTATION IN UM APPEALS AND AUTHORIZATION TO RELEASE OF INFORMATION IN UM APPEALS AND ARBITRATION OF CLAIMS

I, PRINT NAME, by marking [√] (or [x]) and signing below, agree to:

☐ representation by USC in an appeal of an adverse UM determination as allowed by N.J.S.A. 26:2S-11, and release of personal health information to DOBI, its contractors for the Independent Health Care Appeals Program, and independent contractors reviewing the appeal. My consent to representation and authorization of release of information expires in 24 months, but I may revoke both sooner.

☐ release of personal health information to DOBI, its contractors for the Independent Claims Arbitration Program or the Chapter 32 Independent Arbitration System, and any independent contractors that may be required to perform the arbitration process. My authorization of release of information for purposes of claims arbitration will expire in 24 months.

Signature: _____ Ins. ID#:_____ Date: _____

Relationship to Patient: ☐ I am the Patient ☐ I am the Personal Representative (provide contact information on back)

* If the patient is a minor, or unable to read and complete this form due to mental or physical incapacity, a personal representative of the patient may complete the form.

Health Care Provider: The Patient or his or her Personal Representative MUST receive a copy of both sides/pages of this document AFTER PAGE 1 has been completed, signed and dated.

Patient Name_____

Patient Address_____

Attorney Name_____ Phone_____

Attorney Address_____Fax_____

Re: My Pending Lawsuit
Letter of Protection
Lien for Professional services

Dear Attorney_____:

I hereby authorize and direct you, my attorneys, to pay directly to University Spine Center, such sums as may be due and owing them of medical services rendered to me both by reason of this accident and by reason of any other bills, including interest on the unpaid balance of my account, that are due said office and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect University Spine Center. Further, I hereby further give a lien on my case to University Spine Center, against any and all proceeds of my settlement, judgment, or verdict which may be paid to you, my attorneys or myself as the result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly responsible to University Spine Center, for all medical bills submitted by them for services rendered to me and that this agreement is made solely for said payment, additional protection and in consideration of their awaiting payment. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

For consideration received, I, _____, assign to University Spine Center my rights and interest in the personal injury protection endorsement of the automobile liability insurance policy or other insurance policy listed above. This assignment is given with respect to all treatment, care, and diagnostic treatment given by the office of University Spine Center or his employees. By assigning these benefits, I have expressly agreed that the following rights are assigned to University Spine Center.

1) The right to collect from the insurer of the policy with respect to the PIP benefit mentioned above.
2) The right to file a lawsuit or PIP arbitration directly against the insurance company in the name of University Spine Center. Assignee and to designate an attorney of the choosing of them for the purpose of filing said lawsuit.
3) I agree to fully cooperate with the Assignee in the collection of the personal injury protection claim from the insurance carrier, including full cooperation with the attorney chosen by the Assignee, the answering of any Interrogatories, the appearance at any deposition and the appearance at the arbitration or trial if my attendance is required.

I hereby authorize and direct to you, my attorney, to pay directly to University Spine Center such sums as may be due and owing for medical services rendered to me both by reason of this accident and by reason of any other bills that are due their office, and to withhold such sums from any settlement, judgment, or verdict which may be paid to you, my attorney, or myself as the result for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to University Spine Center for all medical bills submitted by them for the services rendered and that this agreement is made solely for University Spine Center additional protection and in consideration of their awaiting payment. And I further understand that such payments is not contingent on any settlement, judgment, or verdict by which I will eventually recover said fee and that payment on the account is due and payable upon demand. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. A photocopy of this Assignment shall be considered as effective and valid as the original.

Print Patient Name: _____ Date: _____

Signature of Patient: _____ Date: _____

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said doctor named above.

Behalf of _____ Law Firm _____ Attorney on_____

Does not apply to me. Initial: _____