

PLEASE COMPLETE NECESSARY INFORMATION

Printed Name _____

Social Security Number _____

Insurance _____

Policy/Certificate Number _____

Is this an injury? _____ Yes _____ No _____

Auto _____ Work _____

What medications are you now taking? _____

Employer _____ Phone(____) _____ - _____

Address _____

Fees are payable at time of service unless arrangements are made in advance.

Patient's signature _____ Date _____

**IRREVOCABLE
ASSIGNMENT, LIEN AND AUTHORIZATION
INSURANCE BENEFITS AND ATTORNEY**

I hereby authorize and direct you, my insurance company and/or my attorney, to pay directly to Carr Chiropractic, **Dr. Timothy J. Carr** such sums as may be due and owing this Office for services rendered me, both by reason of accident or illness, and by reason of any other bills, that are due this office, and to withhold such sums from any disability benefits, medical payment benefits, no-fault and PIP benefits, worker's compensation benefits, or any other insurance benefits obligated to reimburse me from any settlement, judgment or verdict on my behalf as may be necessary to adequately protect this office. I hereby further give a lien to said office against any and all insurance benefits named herein, and any and all proceeds of any settlement, judgment or verdict which may be paid me as a result of the injuries or illness for which I have been treated by this office. This is to act as an assignment of my rights and benefits to the extent of the office's service provided.

I understand I remain personally responsible for the total amounts due this office for services. I further understand and agree that this Assignment, Lien and Authorization does not constitute any consideration for this office to await payments and they may demand payment from me immediately upon rendering services at their option.

I authorize this office to release any information pertinent to my case to any insurance company, adjuster or attorney to facilitate collection under this Assignment, Lien and Authorization. I agree that the above mentioned office be given power of Attorney to endorse/sign my name on any and all checks for payment of my bill.

Date _____

Signature _____

Dr. Timothy J. Carr
Chiropractic Physician

478 South Avenue
Whitman, MA 02382

APPLICATION FOR TREATMENT

Today's Date _____ Referred By _____

Name _____ Date of Birth _____

Address _____ City/Town _____ Zip _____

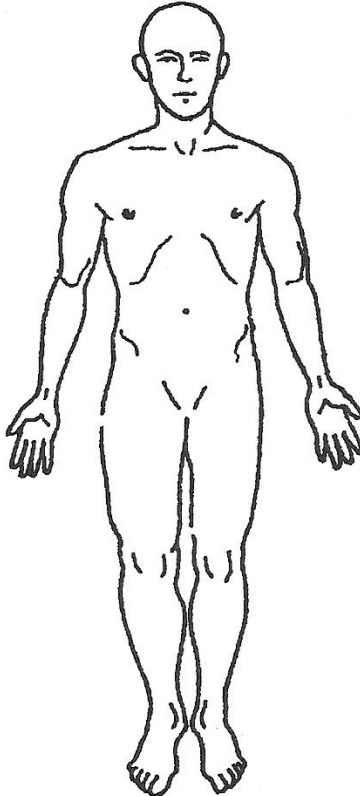
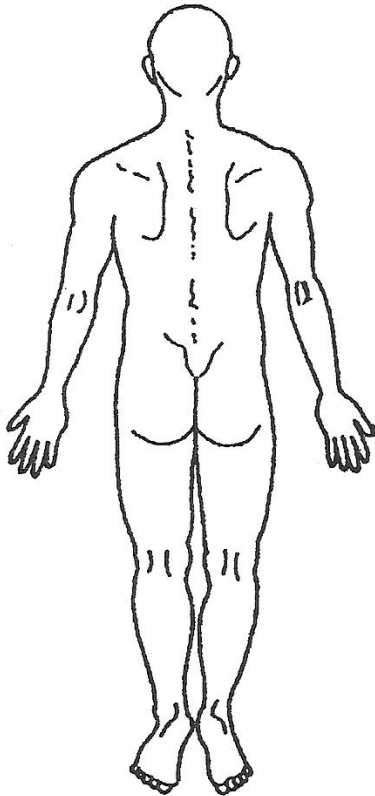
Home Phone () _____ Phone at Work () _____

Cell Phone _____ email address _____

Person Responsible for Payment: Health Insurance _____ Work Injury _____ Auto _____ Self Pay _____

Please indicate by marking the diagrams below the location of your problem. **PROBLEMS/COMPLAINTS**
In the 'Problem/Complaint' column, describe in your own words the problem(s)
that brought you to seek help. At the bottom of the column also identify the items
that pertain to you. 1: _____

COMPLETE THESE DIAGRAMS



2: _____

3: _____

WHEN DID IT START?

HOW DID IT HAPPEN?

My condition is Staying the same _____

Getting worse _____ Getting better _____

My pain is: Dull _____ Sharp _____

Achey _____ Radiating _____ Stiff _____

Constant _____ Off and On _____

My condition is worse with:

Sitting _____ Standing _____

Lying Down _____ Other _____

My condition is better with:

Sitting _____ Standing _____

Lying Down _____ Other _____

INTERSECT THIS LINE TO INDICATE PAIN LEVEL

NONE

WORST