Doctor's Lien

From: Nevada Rehabilitation Centers
"Optimal Injury Care"
6800 W Cheyenne Avenue
Las Vegas, NV 89108
309-HURT4878 Fax (702)658-7117

To: Attorney ______________________________

____

____

RE: Medical Reports and Doctor's Lien

Patient Name:____

NRC Patient #:_____________________ **Date of Injury:**________________________________

I do hereby authorize *Nevada Rehabilitation Centers* to furnish you, my attorney, with a full report of his examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was involved.

I hereby authorize and direct you, my attorney, to pay directly to *Nevada Rehabilitation Centers* such sums as may be due and owing him for medical service rendered me both by reason of this accident and by reasons of any other bills that are due his office and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect *Nevada Rehabilitation Centers* . And I hereby further give a lien on my case to *Nevada Rehabilitation Centers* against any and all proceeds of any settlement, judgment or verdict which may be paid to you, my attorney, or myself as the result of the injuries for which I have been treated or injuries in connection therewith.

I further grant to *Nevada Rehabilitation Centers* a lien, independent of any attorney's lien, upon any claim, settlement, or judgment that I obtain or am entitled to from any insurer, corporation, or person, as a result of my accident, for the complete and total satisfaction of any and all charges I incur at *Nevada Rehabilitation Centers* , and I expressly direct any such insurer, corporation, or person to pay *Nevada Rehabilitation Centers* any charges that I incur as a result of my accident. It is my intent that this lien stay in force until all of my charges at *Nevada Rehabilitation Centers* are satisfied, regardless of whether my attorney signs a lien with *Nevada Rehabilitation Centers* , my attorney withdraws, or I release or substitute one or more attorneys during the course or my injury, claim, or case.

I fully understand that I am directly and fully responsible to *Nevada Rehabilitation Centers* for all medical bills submitted by him for service rendered me and that this agreement is made solely for said doctor's additional protection and in consideration of his 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.

Date: ____________________ Patient's Signature: ____

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 above named.

Date: ____________________ Attorney's Signature: ____

Mr. Attorney: Please date, sign, and return or **fax (702)658-7117** to doctor's office as soon as possible. *Thank You!*

Duties Under Duress Index

Patient Name________________________________ **Date**__________________________

Have you continued to do any of the following activities despite the pain caused by your collision?

❑ ***Work***

Why have you continued to work?

- ❑ I would lose my job if I took time off.
- ❑ I couldn't support my family otherwise.
- ❑ I don't believe in taking time off even when I am injured or in pain.
- ❑ My business would fail if I did not work.
- ❑ I cannot take time off, because I care for my own children.
- ❑ Other: ____

❑ I have experienced the following changes in my ability to perform at work:

a. ❑ Mobility / Stability Problems
   - i. ❑ Climbing
   - ii. ❑ Kneeling
   - iii. ❑ Lifting
   - iv. ❑ Walking for Long Periods

b. ❑ Dexterity Problems
   - i. ❑ Finger Movements
   - ii. ❑ Wrist Movements

c. ❑ Problems with Fatigue

d. ❑ Postural Difficulties
   - i. ❑ Bending
   - ii. ❑ Sitting for Long Periods
   - iii. ❑ Standing for Long Periods
   - iv. ❑ Stooping

e. ❑ Problems with Anxiety / Depression

f. ❑ Problems with Vertigo or Spinning Sensations
   - i. ❑ Dizziness
   - ii. ❑ Giddiness
   - iii. ❑ Sensation of Irregular Motion
   - iv. ❑ Sensation of Whirling Motion

g. ❑ Problems with Tinnitus or Ringing in the Ears

h. ❑ Problems with Reduced Concentration
   - i. ❑ Can't Concentrate
   - ii. ❑ Can't Think Properly
   - iii. ❑ Making Mistakes

i. ❑ Pain
   - i. Where?____

❑ Duration of Symptoms

a. ❑ I experienced problems doing my normal work activities for _____ weeks.

b. ❑ My doctors have instructed me that my inability to perform my normal pre-accident work activities without pain is a permanent condition.

c. ❑ My problems in performing my normal work activities is ongoing, but my doctors have not instructed me that the conditions is permanent.

Duties Under Duress Index

Patient Name________________________________ **Date**__________________________

❑ ***Domestic Duties***

❑ I have experienced pain while performing the following activities *inside* my home, but have done them anyway:

a. ❑ Laundry
b. ❑ Dishwashing
c. ❑ Vacuuming
d. ❑ Washing Windows
e. ❑ Cleaning
f. ❑ Preparing Meals

❑ Due to my injuries, I have brought in the following assistance:

a. ❑ Paid Housekeeper
b. ❑ Unpaid Assistance
c. ❑ None

❑ My family status would best be described as:

a. ❑ Single
b. ❑ Single Parent at Home
c. ❑ Spouse Only
d. ❑ Spouse and Children at Home

❑ I have the following number of children:

a. ❑ 0
b. ❑ 1
c. ❑ 2
d. ❑ 3
e. ❑ 4
f. ❑ 5
g. ❑ ____

❑ The number of my children in the following age category is:

a. ❑ Number of children 0 to 5 years: __________
b. ❑ Number of children 5-11 years: ___________
c. ❑ Number of children older than 11:_________

❑ Domestic Assistance

a. ❑ I do receive domestic assistance
b. ❑ I do not receive domestic assistance

❑ Duration of Symptoms

a. ❑ I experienced problems doing my normal domestic activities for _____ weeks.
b. ❑ My doctors have instructed me that my inability to perform my normal pre-accident domestic activities without pain is a permanent condition.
c. ❑ My problems in performing my normal domestic activities is ongoing, but my doctors have not instructed me that the conditions is permanent.

Duties Under Duress Index

❑ ***Household***

❑ I have experienced problems with the following activities *outside* my home:

a. ❑ Painting the Outside of the House
b. ❑ Landscaping
c. ❑ Mowing the Grass
d. ❑ Trimming the Bushes / Trees
e. ❑ Washing Windows
f. ❑ Gardening
g. ❑ Taking Out the Trash
h. ❑ Washing the Cars
i. ❑ Maintaining the Cars
j. ❑ Maintaining Yard Equipment
k. ❑ Doing Other External House Work; Specify: ______________________________

❑ Duration of Symptoms

a. ❑ I experienced problems doing my normal household activities for _____ weeks.
b. ❑ My doctors have instructed me that my inability to perform my normal pre-accident household activities without pain is a permanent condition.
c. ❑ My problems in performing my normal household activities is ongoing, but my doctors have not instructed me that the conditions is permanent.

Patient Signature __________________________________ ***Date*** __________________________

Duties Under Duress Index **(Student)**

Patient Name________________________________ Date________________________

❑ ***Studies / Educational Duties***

❑ As a student I have experienced problems with one of the following activities since the collision:

a. ❑ Carrying Books
b. ❑ Sitting in Classes
c. ❑ Looking Down to Read Textbooks
d. ❑ Other: ____

❑ I have also experienced the following changes in my ability to perform at school as a result of injuries sustained in this collision:

a. ❑ Mobility / Stability Problems
   i. ❑ Climbing
   ii. ❑ Kneeling
   iii. ❑ Lifting
   iv. ❑ Walking for Long Periods
b. ❑ Dexterity Problems
   i. ❑ Finger Movements
   ii. ❑ Wrist Movements
c. ❑ Problems with Fatigue
d. ❑ Postural Difficulties
   i. Bending
   ii. Sitting for Long Periods
   iii. Standing for Long Periods
   iv. Stooping
e. ❑ Problems with Anxiety / Depression
f. ❑ Problems with Vertigo or Spinning Sensations
   i. Dizziness
   ii. Giddiness
   iii. Sensation of Irregular Motion
   iv. Sensation of Whirling Motion
g. ❑ Problems with Tinnitus or Ringing in the Ears
h. ❑ Problems with Reduced Concentration
   i. Can't Concentrate
   ii. Can't Think Properly
   iii. Making Mistakes
i. ❑ Pain: Where?____

At the time of this collision, my education would best be described as:

a. ❑ High School
b. ❑ Apprenticeship Studies
c. ❑ Technical College
d. ❑ University
e. ❑ Correspondence Course

My attendance <u>before</u> the collision is best described as:

a. ❑ Full Time
b. ❑ Part Time

Patient Signature______________________________ ***Date***__________________

Nevada
Rehabilitation
Centers
"Optimal Injury Care"

Name:____

Date of Injury: ________________________________

General Impairment History

Circle all activities which have been impaired **(now difficult)** in any way by the accident/injury in question:

Daily Activities

bathing/show ering	vacationing	sexual relations	shampooing hair	shopping
bending	dining out	lifting	eating	w atching TV
brushing teeth	movie going	church events	moving	sleeping
dressing	standing	child care	reading	traveling
driving car	sitting	religious activities (bending/kneeling)	shaving	social events

Domestic Activities (Activities within the home)

cooking	w ashing dishes
ironing	vacuuming
housecleaning	dusting
laundry	interior painting
	decorating

Household Activities (Activities outside the home)

trimming bushes	exterior painting
gardening	car w ashing
tree trimming	landscaping
mow ing Law n	house maintenence
yard w ork	farm activities

Work Activities

sitting	reading
standing	bending
lifting	typing
using telephone	w riting
computer w ork	child care

Hobby Activities

aerobic exercise	card playing	gymnastics	jogging/running	musical instruments
archery	camping	health clubs	photography	volleyball
backpacking	dancing	hockey	requetball	w ater skiing
bow ling	fencing	hunting	rafting	w ater sports
badminton	fishing	judo	sailing	w eight lifting
baseball	flying	horseback riding	mountain climbing	
basketball	football	ice skating	sew ing	
basketry	gardening	karate	snow skiing	
bicycling	golf	painting	sw imming	
boxing	handball	yoga	w alking	

Signature: ____ Date: ________________________

Nevada
Rehabilitation
Centers
"Optimal Injury Care"
309-HURT(4878)

Health Care Authorization Form

Patient Name:____ Date__________________________

Patient SS#:_________________________________ Date of Birth_____________________________

The patient identified above, authorizes *Nevada Rehabilitation Centers* to use or disclose protected health information in accordance with the following:

Specific Authorizations

I give permission to *Nevada Rehabilitation Centers* to verify my insurance, use my address, phone number, and clinical records to contact me with appointment reminders and missed appointments. If *Nevada Rehabilitation Centers* contacts me by phone, I give them permission to leave a phone message on my answering machine or voice mail.

I give permission to *Nevada Rehabilitation Centers* to *(please initial below)*:

________Post my testimonial
________Display patient photograph
________Send me a newsletter
________Send a birthday card or holiday related cards information about treatment alternatives or other health related information.
________ Send me an email with health information. ____________________________________
Email Address

_____ (Open Room Authorization – Optional)
Initial I give *Nevada Rehabilitation Centers* permission to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with the doctor at any time in private, the doctor will provide a room for these conversations.

By signing this form you are giving *Nevada Rehabilitation Centers* permission to use and disclose you protected health information in accordance with the directives listed above.

Expiration- The authorization shall expire on the following date: Indefinite

---

The authorization is requested by *Nevada Rehabilitation Centers* for its own use/disclosure of PHI. (Minimum standards apply). You have the right to refuse to sign this AUTHORIZATION. If you refuse to sign this AUTHORIZATION, Nevada Rehabilitation Centers will not refuse to provide treatment.

You have the right to inspect or copy PHI to be used/disclosed.

A copy of the signed authorization will be provided to you upon your request
You may also request a "Right to Revoke Authorization" to terminate this Authorization

I have read and received the "Notice of Privacy Practices for Protected Health Information.

Patient Signature____ Date________________________

Signature of Parent/Guardian____

12-18-07 revised

Nevada Rehabilitation Centers
Confidential Patient Information

Date: ____________________________

Name: ____ Sex: M F Marital Status: M D S W

DOB: _____________________________ Age: ______ SS#: _____________________________________

Home Phone #: ___________________________________ Cell Phone #: ____

Address: ____

City: ____________________________________ State: ___________________ Zip: __________________________

Place of Work: ____ Phone#: ____________________________

Spouse's/Guardian Full Name: _________________________________ Spouse DOB: ______________________________

Work #: _____________________________________ Spouse SS#: ____________________________________

Name and number of nearest relative (not your spouse): ____

Is your visit due to an accident? Yes No Type of Accident: Auto Work Slip/Fall other: ________________
(if Yes, Please see receptionist for injury report.)

Drivers License # and State: ____ Expires on: ___________________________

(if any of the following are relevant to your medical condition, please check the accompanying box)

☐ Cancer	☐ Muscular Dystrophy	☐ Rheumatic Fever	☐ Digestive Disorders
☐ Polio	☐ Multiple Sclerosis	☐ Scarlet Fever	☐ Sinus Trouble
☐ Tuberculosis	☐ Convulsions	☐ Nervousness	☐ Backaches
☐ Epilepsy	☐ High Blood Pressure	☐ Asthma	☐ Numbness
☐ Heart Trouble	☐ Concussion	☐ Dizziness	☐ Arthritis
☐ Diabetes	☐ Hepatitis	☐ German Measles	☐ Venereal Disease

Weight: ______________ pounds **Height:**_____ ft ______in **Are you:** Left handed Right Handed

Past History

Past Motor Vehicle Accidents, surgeries, work injuries, personal injuries, etc. List Physician/Hospital, date injured, each body part injured. For each of those indicate if resolved? If not, level of discomfort 1-10 at time of this accident/injury? Estimated dates add ? next to date.

Physician/Hospital and City	**Date of Accident/Illness**	**Reason** (Each Part of body treated for injury) Before this new accident.	**Did you fully recover?** If Not give pain level
______________________________	____________________	___________________________	Yes NO _____
______________________________	____________________	___________________________	Yes NO _____
______________________________	____________________	___________________________	Yes NO _____
______________________________	____________________	___________________________	Yes NO _____
______________________________	____________________	___________________________	Yes NO _____

Are you currently taking any medication? Yes No What kind? _________________________ Last physical exam Date: ______________

Are you **allergic** to any medication? Yes No What kind? ____

Are you or could you be pregnant? Yes No Date of last menstrual period: _______________________________________

Nevada Rehabilitation Centers
Confidential Patient Information

Do you have **health insurance**? Yes No Insurance Co Name: ___________________________ Phone: ___________________

Policy Holder: _____________________________ ID#:______________________________ Policy group#:_____________________

Do you have secondary insurance? Yes No 2nd Insurance Co Name: ____________________________ Phone: _________________

Policy Holder:___________________________ ID#:____________________________ Policy group#:________________________

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Nevada Rehabilitation Centers (NRC) will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the convenience or credit to my account. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. It is my understanding that my credit may be checked if NRC extends credit to me. I also understand that if I suspend or terminated my care and/or treatment, any fees for professional services rendered to me will be immediately due and payable unless prior arrangements are made. I hereby authorize the doctors at NRC and whomever they may designate as their assistants to administer treatment as they so deem necessary. I also authorize the release of any information acquired in the course of my examination or treatment. I certify that the above information is true and correct.

Signature:____ **Date:**______________________

Please fill out below for all patients under the age of 18.

I give permission for the above minor to be examined/treated by Nevada Rehabilitation Centers and their physicians as they deem necessary.

Relationship to patient: Mother Father Guardian Other:_____________ **Who is responsible for the bill**?____________________

Responsible Party Address: ☐ Same as Patient Street address:____

Apt #::_________ City:________________________ State:________ Zip:________________________

Signature of legally responsible party:____ Date:______________________

Nevada
Rehabilitation
Centers
"Optimal Injury Care"

Pain Chart

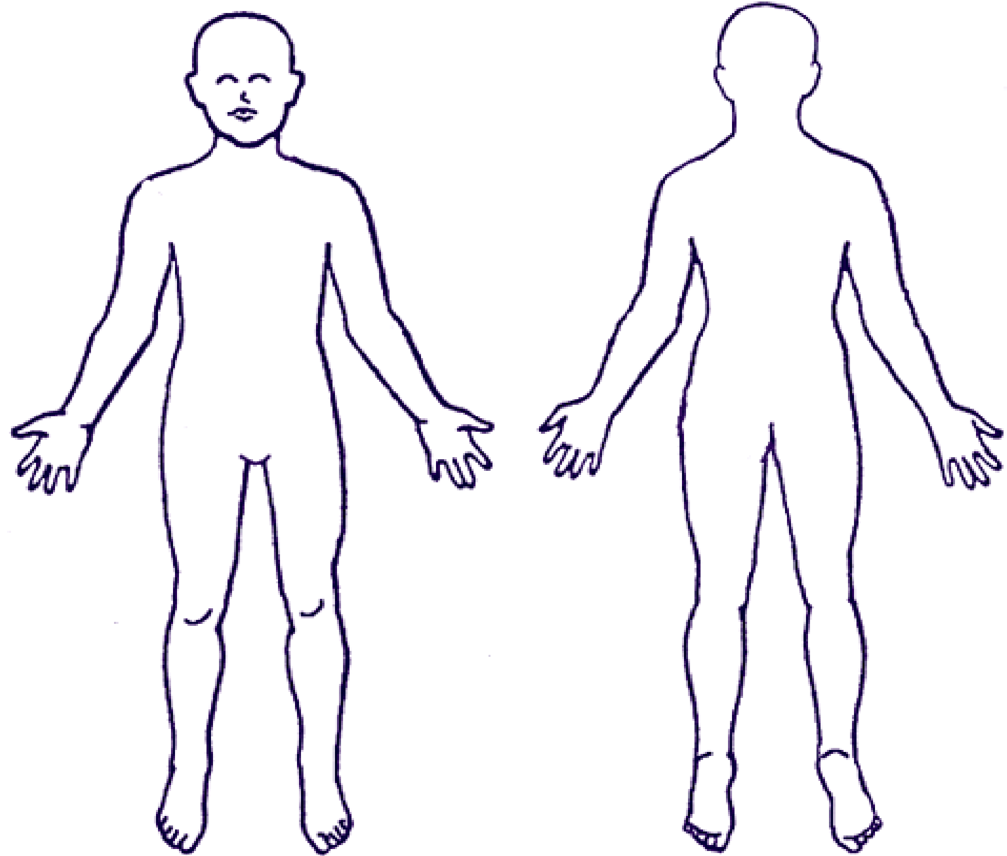
Patient Name:___________________________________ Date of birth:___________________

Please mark the body figure below with the symbols that best describe your pain:

Throbbing	**/ / / / / / / / /**	**Pins and Needles**	**O O O O O O O O O**	**Numbness**	**~ ~ ~ ~ ~ ~ ~ ~ ~**	**Burning**	**XXX XXX XXX**

Sharp & Stabbing **S S S / S S S / S S S**

Dull Ache **D D D / D D D / D D D**



Do you have any of the following? If so, please circle those which apply:

Headaches *Muscle spasms* *Dizziness* *Anxiety* *Loss of Sleep* *Ear Noises (ie buzzing, ringing, etc)*

Please list any other complaints:____

____

____

What are you unable to do since this problem began?______________________________

____

____

Signature:____ Date:______________________

12-17-07 revised

Nevada
Rehabilitation
Centers
"Optimal Injury Care"

Personal Injury

Name ______________________ Date ______________

Address ______________________

City ______________________ State ________ Zip ________

SS# ______________ Phone: ______________

Sex M/F Age ________ DOB ______________

Place of Accident: ______________________

Were you at work when this accident happened? Yes No If Yes, please let the front desk know.
Did you let your supervisor know? Yes No

Date & time of accident ______________________

Where were you taken after the accident? ______________________

Where did you feel pain? ______________________

What are your symptoms? ______________________

____

Name of any other Doctor consulted since your accident: ______________________

Treatment received: ______________________

How often did you receive care from the other Doctor? ______________________

Have you previously been injured in a similar manner? ______________________

Please explain fully how your accident happened:
(Use reverse side if necessary)
Were you inside or outside? ______________________

____

____

____

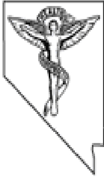
____

____

____

____

______________________ ______________
Patient Signature Date



Nevada Rehabilitation Centers
"Optimal Injury Care"
6800 W. Cheyenne Avenue
Las Vegas, NV 89108
Phone: (702)309-4878 Fax: 658-7117

STAT

Request for Records

All Records of Treatment Including Radiology Reports

Patient is currently in our office. Please send records STAT. Thank you.

*Date:*_____________________ *Date of Injury:**(if Applicable)*___________________

Please list all locations of treatment and include phone numbers.

TO: ________________________________ Phone: ______________________

________________________________ Phone ______________________

________________________________ Phone ______________________

________________________________ Phone: ______________________

I ________________________________ hereby authorize you to release all
Please Print Patient's Name
records/radiology reports to Nevada Rehabilitation Centers. This request expires 12 months from date signed.

____________________ Date of Birth

________________________ Patient, Parent, or Guardian Signature

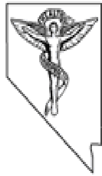
____________________ Social Security Number

________________________ Please Print Name Signed Above

________________________ Relationship to Patient

Please fax the records to **658-7117** **STAT**. The patient is currently in our office for treatment. Thank you in advance for your promptness in this matter.

Nevada Rehabilitation Centers



Nevada
Rehabilitation
Centers
"Optimal Injury Care"

Chiropractic Physiotherapy and Rehab

Signature on File

I understand that as a courtesy to me, *Nevada Rehabilitation Centers* will verify my insurance coverage. Unfortunately, on occasion, the information given to them is not correct. I also understand that it is hard for *Nevada Rehabilitation Centers* to know how much I will owe and that the amount given to me is only an estimate. The amount may be high or low and may change with different therapies done in the office. The amount will be adjusted according to the explanation of benefits from my insurance company.

By signing below I understand that ultimately ***I am*** responsible for my bill. I also understand that it is my responsibility to let Nevada Rehabilitation Centers know if there is any change in my insurance coverage. *Nevada Rehabilitation Centers* does not bill secondary insurances.

I authorize *Nevada Rehabilitation Centers* to use this form on all my insurance submissions. I also authorize release of information to all of my insurance companies. I authorize my doctor to act as my agent in helping me obtain insurance payment from my insurance company/companies or attorney. I authorize payment to be made directly to my doctor. I permit a copy of this authorization to be used in place of the original. Attorney liens are to be paid at time of settlement. I understand that I am responsible for my bill.

Name____
Please Print

Signature_______________________________________ Date__________________________