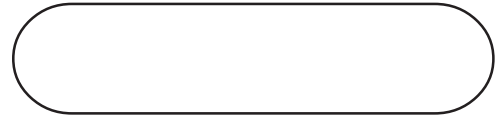


CASE HISTORY

(Please Print)



Address _____ Phone _____

City _____ State _____ Zip _____ Email: _____

Married _____ Single _____ Number of Children _____

AGE _____ PREFERRED LANGUAGE _____ DATE OF BIRTH _____ GENDER _____

Race: Caucasian African American Hispanic Asian Other _____ Ethnicity(origin ex. German) _____

Employed by _____ Business Phone _____

Referred by _____

Have you had chiropractic care before? _____ Where? _____

Social Security No. _____ Who is responsible for account? (if minor) _____

(NAME) (ADDRESS)

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Chiro-Works will prepare any necessary report and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Chiro-Works will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. (I further understand that any unpaid balance of 60 days or more will be charged 1.5% interest on the unpaid balance each month.) In the event that I fail to pay the amounts when due, I understand that I will be in default of our agreement.

DELINQUENCY AND DEFAULT: I AGREE TO PAY THE COSTS INCURRED TO COLLECT THIS BILL IN THE EVENT OF MY DEFAULT IN PAYMENT, INCLUDING YOUR REASONABLE ATTORNEY'S FEES.

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL MEDICAL RECORDS AND/OR INFORMATION

I authorize Chiro-Works to release any medical information or X-rays as needed to process claims for services rendered. I understand that this release is revocable at any time prior to the release of this information.

ASSIGNMENT OF PAYMENT

My attorney and/or insurance company are hereby requested and authorized to pay direct to Chiro-Works any monies due on account, the same to be deducted from any settlement made on our behalf.

Further, I agree to pay Chiro-Works the difference, if any between the total amount of charges and the amount paid by the attorney and/or insurance company. It is further understood that I, the undersigned, agree to pay Chiro-Works the full amount of charges, should my condition be such that it is not covered by my policy or it for any reason the insurance company refuses to pay my claim.

Dated at 1019 W. Galena Ave., Freeport, IL 61032 this _____ day of _____, 20_____.

Witness:

Signature of Patient or Legal Guardian