VALLEY WELLNESS HEALTH GROUP

(Ly Chiropractic, Inc)

(Personal Injury Questionnaire)

Information about You:

Name _____ Phone_____

Address _____ City _____ State _____ Zip _____

Age _____ DOB _____ Sex ( )F ( )M SSN: _____Email: _____

Employer's Name _____ Employer's Address _____

Your Ins. Co. _____ Policy Nr _____ Agent's Name

_____ Name on Policy (if other than self)

_____ Responsible Party's Name

_____ Policy Nr _____ Address

_____ City _____ State _____ Zip _____ Policy

Holder's Name _____

Information about Your Attorney

Name _____ Ph _____ Fx _____

Address _____ City _____ State _____ Zip _____

Were there any witnesses? ( ) Yes ( ) No Names

_____ **Information about Your Accident**

Date of Accident _____ Time of Day _____

Were you: ( ) Driver ( ) Passenger ( ) Front Seat ( ) Back Seat

Number of people in your vehicle? _____ Were you wearing seatbelts? ( ) Yes ( ) No

What direction was you headed? ( ) North ( ) East ( ) West ( ) South

What direction was the other vehicle headed? ( ) North ( ) East ( ) West ( ) South

On (name of street) _____

Were you struck from: ( ) behind ( ) front ( ) Left Side ( ) Right Side

Approximate speed of your car _____ mph Other car _____ mph

Were you knocked unconscious? ( ) Yes ( ) No If yes, for how long? _____

Were policy notified? ( ) Yes ( ) No

In your own words, please describe the accident: _____

_____

_____

Did you have any physical complaints before the accident? ( ) Yes ( ) No

If yes, please describe: _____

_____

_____

Please describe how you felt:

During the accident: _____

Immediately after the accident: _____

Later that day: _____

The next day: _____

What are your present complaints and symptoms? _____

_____

_____

Where were you taken after the accident? _____

Have you been treated by another doctor since the accident? ( ) Yes ( ) No

If yes, please write down their names: _____

Since the injury occurred, are your symptoms ( ) improving ( ) getting worse ( )Same

CHECK SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT:

( ) Headache	( ) Irritability	( ) Numbness in toes	( ) Flushed face
( ) Neck pain	( ) Chest pain	( ) Shortness of breath	( )Buzzing in ears
( ) Stiff neck	( ) Dizziness	( ) Fatigue	( ) Loss of balance
( ) Difficulty sleeping	( ) Head is heavy	( ) Depression	( ) Fainting
( ) Back pain	( ) Pin/Needles in arms	( ) Light sensitive eyes	( ) Loss of smell
( ) Nervousness	( ) Pin/Needles in legs	( ) Loss of memory	( ) Loss of taste
( ) Tension	( ) Numbness in fingers	( ) ringing ears	( ) Diarrhea
( ) Cold feet	( ) Cold hands	( ) Upset stomach	( ) Constipation
( ) Cold sweats	( ) Fever	( ) _____	( ) _____

Do you have any congenital (from birth) factors which relate to this problem? _____

_____

_____

Do you have any previous illnesses that relate to this case? ( ) Yes ( ) No

If yes, please describe: _____

_____

Have you ever been involved in an accident before? ( ) Yes ( ) No

If yes, please describe, including date(s) and type(s) of accident(s) as well as injuries suffered:

_____

_____

_____

Have you lost time from work as a result of this accident? ( ) Yes ( ) No

Last day worked: _____

Type of Employment: _____

Do you notice any activity restrictions as a result of this injury? ( ) Yes ( ) No

If yes, please describe: _____

_____

Other pertinent information: _____

_____

_____ _____

Date Patient's Signature

VALLEY WELLNESS HEALTH GROUP

4950 Hamilton Ave, Ste. 109, San Jose, CA 95130

Name: _____ Date of Injury: _____ Date:_____

(1) Please describe the cause of your current symptoms:

[] Got Rear Ended [] In the Police report [] Passenger / Driver
[] Other (describe below)

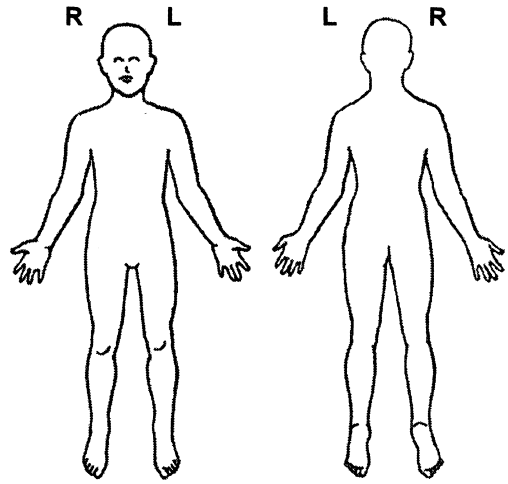
_____

_____

(2) Please check box or write down the area(s) of your injury/pain:

[] Neck pain
[] Upper back pain
[] Middle back pain
[] Lower back pain
[] Pain along the spine
[] (R)/(L) Shoulder pain
[] (R)/(L) Elbow pain
[] (R)/(L) Wrist/Hand pain
[] (R)/(L) Hip pain
[] (R)/(L) Knee pain
[] (R)/(L) Ankle pain
[] (R)/(L) Heel/Foot pain
[] (R)/(L) Ribs (back/front) pain
[] (R)/(L) Chest/Sternum/Waist pain
[] Headaches [] Dizziness [] Lose of sleep [] Anxiety
[] Shortness of breath [] Weakness
[] Other area(s): _____

NOTES:



I declare under penalty of perjury of the State Of California that the foregoing statement is true and correct.

X_____ _____

Patient Signature Date

HIPPA

PATIENT RIGHTS TO PRIVACY RULES:

In accordance to federal law, we are required to disclose this form to you to inform you of your rights to privacy.

During certain circumstances, we may have to release your health information to an outside party.

- We may have to disclose your health care information to another provider if it is decided it is necessary for referral, testing, or treatment
- We may have to disclose your health care and billing information to a third party if they are responsible for payments to your accounts
- We may have to disclose your health care information within our practice for operational purposes and quality control

Your Right To Limit Or Restrict The Uses Of Your Health Care Information

You do have the right to request for limitations to be put on who we disclose your health care information to; such as specific individuals, companies, or organizations. Should you like to request any restrictions on the use or disclosure of your health care information, please inform us in a written statement. We are not required to agree to any restrictions, however the restriction is binding should we agree to it.

We are required to house and provide you with a copy of the HIPAA Compliance Manuel upon request for a fee, and you have a right to file a complaint to the office designated Compliance Officer.

As always, you have a right to get answers to all of your questions and concerns to the best of our knowledge.

By your signature below you certify that you are a current or prospective patient at Ly Chiropractic, Inc / Valley Wellness Health Group and that you have read and understand your privacy rights as outlined above.

Print Name: _____

Signature: _____ Date: _____

INFORMED CONSENT

PATIENT NAME: _____

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The Nature of Chiropractic Adjustment:

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy and will use this procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints, which may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. This may cause you to feel a sense of movement.

Analysis, Examination, and Treatment:

As a part of the analysis, examination, and treatment, you are consenting to the following procedures:

- Spinal manipulative therapy, vital signs, range of motion testing, Chiropractic testing, Orthopedic testing, Neurological testing, radiographic studies.
- Physical therapy modalities such as: Ultrasound, Electrical Stimulation, Paraffin, Intersegmental therapy, Massage, Heat or Cold therapy

The Material Risks Inherent in Chiropractic Adjustment:

As with any health care procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include, but are not limited to: fracture, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck, leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care, however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The Possibility of the Risks Occurring:

Fractures are rare occurrences and generally result from underlying weakness of the bone which I will check for during the taking of your history, examination, and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare, estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

I have read an explanation of the chiropractic adjustment and related treatments. I have disclosed with Valley Wellness Health Group / Ly Chiropractic, Inc and have had my questions answered to my satisfaction in that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I am giving my consent to treatment.

Patients Name: _____ Signature: _____ Date: _____

Parent/Guardian (if a minor): _____ Signature: _____ Date: _____

Doctor's Name: Tam Ly, D.C. Signature: _____ Date: _____

OFFICE POLICY

LY CHIROPRACTIC, INC (DBA: VALLEY WELLNESS HEALTH GROUP)

Thank you for choosing Dr. Ly and his staff as your health care providers. We are committed to providing you with caring, comprehensive, quality health care. The following is a summary of our office policies. We believe a clear definition will allow us both to concentrate on the most important issue: ***regaining and maintaining your health***.

Payment Policy:

We feel the patient's health needs are paramount; therefore we have maintained a pricing structure that allows care for all budgets. We accept most Insurance Plans, including Auto Accident and Worker's Compensation.

Payment is expected in full at the time of each visit. We take Visa, MasterCard, Care Credit, Cash and Check. In the event a check is returned for non-sufficient funds, you will be responsible to cover the fees incurred by Valley Wellness Health Group.

Patients who opt to pay for services as a treatment package will receive a discount on usual and customary rates. Patient has the right to discontinue/cancel treatment package purchased by providing 10 days notice. Patient will lose any discounted rate and accumulated visits will be based on the usual and customary fee. Any remaining visits, balance due or balance owed will be refunded or billed to the patient and due at time of cancellation.

Insurance Policy:

Today most insurance policies cover Chiropractic/Massage. As a courtesy to our patients we will check your benefits for you and provide you with a comprehensive summary of benefits but it is ultimately your responsibility to know your coverage levels.

Remember, your insurance is an agreement between you and your insurance company, not between your insurance company and our office. Benefits quoted to us by your insurance company are not a guarantee of payment. As a courtesy to you our office will file any necessary forms at no additional charge. It is to be understood and agreed that any services rendered are charged to you directly and you are responsible for payment of any non-covered services, deductibles or co-pays.

If your insurance company sends payment for services rendered to you, please notify and forward payment(s) to Valley Wellness Health Group, so that your account may be credited accordingly.

Chiropractic Appointment Cancellations:

In order to better serve our patients we ask you call ***24 hours in advance to CANCEL or CHANGE*** your appointment. Your appointment time is reserved specially for YOU. If you fail to notify the office, it leaves an open appointment that could be used to help someone else like yourself.

ALL "no show" appointments and appointments cancelled same-day will be subject to a ***$25 cancellation fee*** due on your next visit. ***All Pre-paid packages will lose that chiropractic visit***.

Prepayment packages/visits/copays, etc:

Any prepayments to include but not limited to packages, visits, copays, etc expire 1 year from the date of payment unless otherwise stated or directed by the doctor. That is any prepayment package, visit, etc must be used within 1 year and upon expiration amount paid is forfeited with no carry over.

I have read and understand the office policy of Valley Wellness Health Group. I have indicated my understanding and agree to abide by these policies by my signature below.

Name: _____

Signature: _____ Date: _____

ASSIGNMENT OF BENEFITS

Patient Name: _____ Insurance Policy Name:_____

Subscriber Employer: _____Claim / Group #: _____ Subscriber ID:_____

I _____ (Print Name) hereby authorize benefits to be assigned to Tam Ly, D.C, for healthcare services provided to me by Tam Ly, D.C. I hereby certify that the insurance information that I have provided Tam Ly, D.C., is true and accurate as of the date of service and that I am responsible for keeping it updated. I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my medical bill is paid in full. I also understand that my insurance company may not pay 100% of the amount of the medical claim and I may be responsible for any and all amounts not payable by my insurance company including any portion paid and not applied to in network benefits for any out of network services.

I hereby authorize Tam Ly, D.C., to submit claims, on my behalf, to the insurance company listed on the copy of the current insurance card I have provided Tam Ly, D.C., in good faith. I fully agree and understand that the submission of a claim does not absolve me of my responsibility to ensure the claim is paid in full.

I hereby irrevocably, designate, authorize and appoint Tam Ly, D.C., as my true and lawful attorney-in-fact. This power of attorney is hereby provided for the limited purpose of receiving all payments due under my policy/medical care plan on account of medical services and care rendered or to be rendered. This power of attorney shall automatically terminate, without formal action being taken, as soon as Tam Ly, D.C., has received payment in full and remedies under applicable regulatory guidelines for all medical care services provided to patient. I hereby confirm and ratify all actions taken by my attorney-in-fact pursuant to the authority granted herein. I hereby authorize my insurer to assign and transfer any applicable ERISA plan benefits and rights to Tam Ly, D.C., including the right to receive any applicable plan documents/remedies, pursue appeals and litigation on my behalf. This authorization includes any other rights due me permissible under state and federal laws.

I hereby instruct and direct the_____ _____insurance company to pay by check made out and mailed directly to:

Tam Ly, D.C.
LY CHIROPRACTIC, INC
DBA: Valley Wellness Health Group
4950 Hamilton Ave, Ste. 109
San Jose, CA 95130

I understand under ERISA that I have the right and authority to direct where payment for services rendered is sent. If my current policy prohibits direct payment to the provider of service, I under my rights per state and federal ERSIA regulations hereby instruct and direct my Insurance Company to provide SPD documentation stating such non-assignability clause to myself and Valley Wellness Health Group. Upon proof of non-assignability documentation, I hereby instruct that the insurer make out the check to me and mail it directly to:

Tam Ly, D.C.
LY CHIROPRACTIC, INC
DBA: Valley Wellness Health Group
4950 Hamilton Ave, Ste. 109
San Jose, CA 95130

for the professional or medical expense benefits, and otherwise payable to me under my current insurance policy as payment towards the total charges for the professional services rendered.

I agree and understand that any funds I receive by my insurance company due for services rendered by Tam Ly, D.C. will be immediately signed over and sent directly to Valley Wellness Health Group, in care of Tam Ly, D.C.

This is a direct assignment of my rights and benefits under this policy. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment. Upon receipt of said check, I authorize Tam Ly, D.C. to receive any such checks, endorse them for deposit only, and to deposit and apply all the proceeds toward payment on my account. I authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

I authorize Tam Ly, D.C., to be my personal representative, which allows Tam Ly, D.C., to: (1) submit any and all appeals when my insurance company denies me benefits to which I am entitled, (2) submit any and all requests for benefit information from my insurance company, and (3) initiate formal complaints to any State or Federal agency that has jurisdiction over my benefits. I fully understand and agree that I am responsible for full payment of the medical debt if my insurance company has refused to pay 100% of my benefits based on billed charges, within ninety (90) days of any and all appeals or request for information.

I authorize Tam Ly, D.C. and its associates to provide medical care reasonable by today's standards. A photocopy of this Assignment shall be considered as effective and valid as the original.

_____ _____
(Signature of Patient) (Date of Agreement)

_____ _____
(Signature of Policy Holder) (Witness/Employee)

Valley Wellness Health Group, Dr.Tam Ly, D.C.
4950 Hamilton Ave, Ste. 109, San Jose, CA 95130, Ph: 408-256-3865 · Fax: 408-550-1974

SECURED DOCTOR'S LIEN, ASSIGNMENT, AND LIMITED POWER OF ATTORNEY

I _____(patient name) residing at _____(address) hereby enter into the following agreement with Dr. Tam Ly, D.C., hereafter known as "the Provider" in order to guarantee payment for services rendered by the Provider to me. I understand that I am directly and fully responsible to the Provider for all health care bills for services rendered to me in the past, present, and future. I understand that I am directly and fully responsible to the Provider for any remaining balance on all health care bills for services rendered to me that were submitted on my behalf to the responsible insurance carrier. This document further serves to acknowledge my responsibility to repay **all** remaining balances subsequent to all applicable insurance payments. I agree to make myself available to appear or correspond with the Provider as often as may be necessary for any collections effort that is undertaken.

The Provider agrees to seek compensation from the appropriate insurance carrier prior to invoking the terms of this lien based on the accuracy of the information the patient has provided. The patient shall provide all necessary insurance information, police reports, and any additional documentation or information deemed necessary by the Provider for the submission of the aforementioned insurance claim as applicable. I agree to comply with all Insurance Company regulations including, but not limited to examinations under oath and independent medical examinations. Failure to provide accurate insurance information leading to a viable source of coverage may serve to interfere with obtaining available insurance benefits, including payment to the Provider.

I hereby give and grant this lien on my case to the Provider against any and all proceeds of any settlement, judgment, verdict, or other disposition of any litigation filed or contemplated on my behalf that may be paid to me OR MY ATTORNEY as a result of the injuries for which I have been treated. I grant the Provider this lien against such sums of any settlement, judgment, verdict, or other disposition of any litigation filed or contemplated on my behalf as may be necessary to adequately reimburse the Provider for services rendered to me and towards all outstanding balances. I hereby agree to provide accurate contact information for the attorney pursuing any litigation on my behalf.

In consideration for the named Provider having agreed to treat me without immediate payment at the time of service and enabling me to obtain treatment for my accident/injury/illness without financial hardship with payment of these services to be made no later than the conclusion of the Patient's(s') claim(s) relating to this accident/injury/illness, I give the Provider an irrevocable lien on my cause(s) of action and an irrevocable assignment of funds derived from this/these cause(s) of action with any settlement, claim, judgment, verdict, award, result, or otherwise of my accident/injury/illness. This is done for the purpose of securing actual payment of all fees owed to the named Provider by the below named patient(s) as and when such funds are received. This lien is secured with any and all real and personal property I own at the present time as well as in the future.

I also understand that if the settlement does not cover my bill with the Provider, I am still personally responsible and liable for the remainder, and the payment by me of this bill is not contingent on any settlement, claim, or judgment which I/we may eventually recover. Payment must be made by Patient(s)/Guardian(s) at the conclusion of Patient's(s') claim(s) regardless of whether any and how much money is received through this/these claim(s).

The Patient(s) grant(s) to the Provider a Limited Power of Attorney to receive funds, negotiate any drafts or checks, and to execute any documents related to payment for services rendered to me.

I hereby **direct** and **authorize** direct payment to the Provider such sums as may be due and owing for health care services rendered to me. I further direct my ATTORNEY to honor this lien and to withhold such sums from any settlement, judgment, verdict, or other disposition of any litigation filed or contemplated on my behalf as may be necessary to adequately reimburse the Provider for services rendered to me towards all outstanding balances.

I understand that this document is irrevocable, may not be rescinded, and that my ATTORNEY shall not honor any such rescission. I hereby instruct that in the event another ATTORNEY is substituted in my case, the new ATTORNEY honor this lien as inherent to the settlement, judgment, verdict, or other disposition of any litigation filed or contemplated on my behalf and enforceable upon the case as if it were executed by him/her. I hereby direct my ATTORNEY, on demand, to provide the status of such litigation to the Provider or his attorney engaged in any collection efforts. Furthermore, I direct my attorney to contact the Provider prior to disbursement of any funds to ascertain any outstanding balances due and owing.

Patient's/Guardian's Signature: _____ Dated: _____

Patient's/Minor's Printed Name(s): _____

* * * * *

ATTORNEY'S ACCEPTANCE OF LIEN

Being the attorney of record or authorized representative, I acknowledge receipt of this Doctor's Lien and agree to honor it.

_____ _____
Attorney's Signature & Information Date