Personal Injury Questionnaire

INFORMATION ABOUT YOU

Cell Phone#: _____

Name_____Phone#:_____

Address _____ City _____State _____ Zip_____

Age _____ Birthdate _____Sex: ( ) M ( ) F _____ S.S.#: _____

Employer's Name _____ Employer's Address: _____

Your Ins_____ POLICY# _____Name on Policy (if other than self)

Responsible Party's Name _____

Address _____Policy Holder's Name _____

PLEASE DRAW A MAP OF HOW YOUR ACCIDENT TOOK PLACE:

INFORMATION ABOUT YOUR ACCIDENT

1. Date of Accident _____ Time of Day _____
2- Were You: ( ) Driver ( ) Passenger ( ) Front Seat ( ) Back Seat
3- Number of people in your vehicle? _____ Were you wearing seat belts? (Yes) (No)
4. What direction were you headed? ( ) North( ) East ( ) South( ) West
5. What direction was the other vehicle headed? ( ) North( ) East ( ) South ( ) West

on (name of street) _____
6. Were you struck from: ( ) Behind ( ) Front ( ) Left side ( ) Right side
7. Approximate speed of your car mph _____ Other car _____mph
8. Were you knocked unconscious? ( ) Yes ( ) No If yes, for how long? _____
9. Were police notified? ( ) Yes ( ) No
10. In your own words, please describe the accident: _____
_____
_____

11. Did you have any physical complaints BEFORE THE ACCIDENT? If yes, describe: _____
_____

12. Please describe how you felt.
a. DURING the accident _____

b. IMMEDIATELY AFTER the accident: _____

c. LATER THAT DAY: _____

13. What are your PRESENT complaints?

_____

_____

14. Do you have any congenital (from birth) factors which relate to this problem? (Yes) (No)

_____

15. Do you have any previous illness which relate to this case? (Yes) (No)

_____

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

If Yes, Please describe, including dates and types of accidents as well as injuries:

_____

_____

17. Where were you taken after this accident?

_____

18. Have you been treated by any doctor, hospital, clinic and/or medical facility since this accident?
If yes: names: _____

19. Since the injury occurred are your symptoms ( ) Getting worse ( ) Same

20. CHECK SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT:

Headache:	Yes	No	Location: _____			Feet Cold	Yes	No
Buzzing in the Ears:	Yes	No	Both Left Right			Hands Cold	Yes	No
Ringing in the Ears:	Yes	No	Both Left Right			Stomach Upset	Yes	No
Dizziness:	Yes	No	Pins & needles hands / feet	Yes	No	Constipation	Yes	No
Nausea:	Yes	No	Numbness in hands /feet	Yes	No	Cold Sweats	Yes	No
Vomiting:	Yes	No	Anxious:	Yes	No	Los of taste	Yes	No
Vertigo:	Yes	No	Difficulty Sleeping:	Yes	No	Fainting	Yes	No
Blurry Vision:	Yes	No	Photophobia:	Yes	No	Face Flushed	Yes	No
Chest Pain:	Yes	No	Phobia of driving:	Yes	No	Fever	Yes	No
Abdominal Pain:	Yes	No	Head is heavy:	Yes	No	Other:		
Problem breathing:	Yes	No	Memory Problem:	Yes	No	_____		
Cough:	Yes	No	Loss of Balance:	Yes	No	_____		
Depressed:	Yes	No	Weakness of hands /feet:	Yes	No	_____		
Loss of taste:	Yes	no	Diarrhea:	Yes	No	_____		

Have you lost time from work as a result of this accident? (Yes) (No) How many days?:_____

Last day Worked: _____ Type of Employment: _____ Salary: _____

Do you Notice any activity restriction as a result of this injury/accident? (Yes) No)
Explain: _____

_____ _____

Date: Patient's Signature

BACK IN MOTION

ROBERT BENTLEY ARMANI, D.C., Q.M.E.
NICK AVEDIKIAN, D.C.
14545 SYLVAN STREET VAN NUYS, CA 91411
TEL: 818-782-2225 FAX: 818-785-2225

Patient's Name:_____Date:_____

DOI: _____

STATEMENT UNDER PENALTY OF PURJURY

PLEASE READ THIS BEFORE SIGNING, IF YOU DO NOT UNDERSTAND THIS, PLEASE ASK FOR A TRANSLATION. I UNDERSTAND THAT I WILL BE PHOTOGRAPHED BY THIS OFFICE AND THIS PHOTO WILL BE IN MY FILE FOR FURTHER IDENTIFICATION. I HAVE NOT MADE ANY MISREPRESENTAION WITH REGRDS TO MY ACCIDENT/INJURY TO DR. AVEDIKIAN / DR. ARMANI AND/OR THEIR EMPLOYEES/CLERKS/OFFICE STAFF.

ANY PERSON WHO MAKES OR CAUSES TO BE MADE KNOWINGLY FALSE OR FRAUDULENT MATERIAL STATEMENT OR MATERIAL REPRESENTATION FOR PURPOSES OF OBTAINING OR DENYING PERSONAL INJURY BENEFIT OR PAYMENTS IS GUILTY OF A FELONY.

I HEREBY DECLARE UNDER THE PENALTY OF PERJURY THAT IN FACT I WAS INJURED DUE TO A CAR ACCIDENT AND ALL OR PARTS OF MY SYMPTOMS ARE THE RESULT OF THE ABOVE DATED INJURY.

I DECLARE THAT I WAS NOT PAID MONEY OR SOLICITED IN ANY WAY OR BY ANYONE TO FILE THIS CLAIM.

I UNDERSTAND THAT THE INFORMATION I AM GIVING TO MY DOCTOR, DR. ARMANI, DR. AVEDIKIAN/BACK IN MOTION AND THEIR STAFF IS ACCURATE INFORMATION TO THE BEST OF MY KNOWLEDGE, I UNDERSTAND THAT THIS INFORMATION REGARDING MY INJURY WILL BE USED IN A MEDICAL LEGAL REPORT, AND IN COURT.

Signature:_____Date:_____

Witness:_____ Doctors signature: _____

Informed Consent To Chiropractic Treatment

I hereby request and consent to the performance of Chiropractic adjustments and any other Chiropractic procedures, including but not limited to Physical Examination, Chiropractic Examination Tests, Diagnostic X-rays/MRI/CT Scan/Ultrasound/Blood Test and physical therapy techniques, on me (or on the patient named below for which I am legally responsible) which are recommended by the doctor of Chiropractic named below and/or other licensed doctors of Chiropractic who now, or in the future, render treatment to me, while employed by, working for, or associated with, or serving as backup for the doctor of Chiropractic named below.

I understand that, as with any health care procedures, there are certain complications or adverse effects/side effects which may arise during a Chiropractic adjustment. Those complications include, but are not limited to fractures, disc injuries, dislocations, muscle strain, Homers Syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. 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. I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedures which the doctor feels at the time, based upon the facts then known, are in my best interest. I understand that some of the treatments are performed or placed on my body by the doctor's assistant under the doctors supervision as prescribed by him. I have had an opportunity to discuss with the doctor named below and/or with office personnel the nature, purpose and risks of Chiropractic adjustments and other recommended procedures and have had my questions answered to my satisfaction. I understand that the results are not guaranteed. I have read or ( ) have had read to me ( ) the above explanation of the Chiropractic adjustment and related treatment. By signing below I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the Chiropractic treatment recommended. Having been informed of the risks, I hereby acknowledge and give my full consent to that treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment. I have had the opportunity to verbally give me consent.

ROBERT BENTLEY ARMANI, D.C., Q.M.E./NICK AVEDIKIAN, D.C./ BACK IN MOTION
14545 SYLVAN STREET
VAN NUYS, CA 91411

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE

Print The Patient's Name: _____ **Date:** _____

Signature of The Patient: _____ **Date:** _____

Signature of Patient's Representative: _____ **Date:** _____

Witness to Patient's Signature: _____ **Date:** _____

Translated By: _____ **Date:** _____

HIPPA AUTHORIZATION FOR RELEASE RECORDS AND OR DISCLOSURE OF MEDICAL INFORMATION

Treatment, payment, enrollment or eligibility for benefits will not be conditioned on my providing or refusing to provide this authorization.

Please **REQUEST** medical information **FROM**:

_____
Name of healthcare provider

_____
Name of medical office/Hospital

_____
Street Address

_____
City, state, and zip code

Please **SEND** medical Information **TO**:
BACK IN MOTION / NICK AVEDIKIAN, D.C.
ROBERT BENTLEY ARMANI, D.C., Q.M.E.
Name of person or entity to receive information

_____
Title (physician, Therapist, Attorney)

_____
Street Address

_____
City, state, and zip code

I hereby authorize _____ to release and / or disclose the medical information as indicated below to health care provider, entity, or person I have indicated above. Release and or disclose records and information regarding:

_____ _____ _____
Name of Patient (List other names used) Record Number# DOB

_____ _____ _____
Address City Zip code Tel Number

Duration: This authorization shall become effective immediately and shall remain in effect until _____ or for two weeks from the date of signature if no date entered.

Revocation: This authorization may be revoked in writing by the undersigned at any time prior to the release of information from the disclosing party. Written revocation will not affect any action taken in reliance on this authorization before the written revocation was received.

Re-disclosure: I understand that the requester may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless disclosure is specifically require or permitted by law.

Specify records To be released and / or Disclosure: Check the box and initial which type of information is to be released and / or disclosed:

_____ General Medic al Information (From:_____ to _____)

_____ Information Regarding Specific Injury or Treatment (From:_____ to present)

_____ X-rays (check on or both): all Films all Reports

_____ Laboratory results _____ Other Digital pictures

I request that the health information released and / or disclosed pursuant to this authorization be used for the following purpose only: _____

A copy of this authorization is valid as an original. I have the right to receive a copy of this authorization. The copy is for me to keep.

_____ _____
Date: Signature of patient or patient's representative (indicate)

BACK IN MOTION

ROBERT BENTLEY ARMANI, D.C., Q.M.E.
NICK AVEDIKIAN, D.C.
14545 SYLVAN STREET VAN NUYS, CA 91411
TEL: 818-782-2225 FAX: 818-785-2225

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE

I, hereby, declare under penalty of perjury under all of the laws of the United States of America, the following: I am not a representative, an agent, an employee and/or sent here by any of the Law Enforcement Agencies, I am not here from the Department of Insurance, I am not sent here by and/or I am not an employee, I am not a member, I am not affiliated, I am not an agent, I am not a decoy and/or I do not belong to any Police department, any Sheriffs office, US marshal's office, State Police, FBI, District Attorney's office, Department of Insurance, CIA, I am not a representative, an agent, an employee and/or sent here by any SIU of insurance company, insurance company Adjuster, I am not a representative, an agent, an employee and/or sent here by any NEWS/Media organization, agency, investigative reporter, any investigator of news and Media organization, I am not a representative, an agent, an employee and/or sent here by any investigator and/or inspector of Federal/state/county/city. I am not carrying any firearms, camera recorders, voice recorders, digitals recorders and/or "Bug". I am not wearing and/or carrying in my purse, my bag, my pocket and/or in my clothing any recording devices, microphones, "bug", any two way microphones, I am not carrying on me, myself, my person or in my bag/suitcase/my clothing any surveillance devices of any kind, I am not recording at this office by voice recorder, sound recorder, video, cell phone, camera and or any other mode. I am not conducting any form of surveillance by any way, form or fashion. I am not recording my visits here at this office by any way, form or fashion, electronically and/or digitally. I am not wearing or carrying any listening devices, walky-talky, tape recorder, cell phone camera recorder, video recorder, DVD recorder, voice recorder. I am not documenting and/or recording my visits her at this office by any way, form or fashion. I am not recording my sessions in this office by any way, form or fashion, digitally, electronically and or any other way.
I hereby swear and declare under penalty of perjury that all of the above is true and accurate.

Print The Patient's Name: _____ **Date:** _____

Signature of The Patient: _____ **Date:** _____

Signature of Patient's Representative: _____ **Date:** _____

Witness to Patient's Signature: _____ **Date:** _____

Translated By: _____ **Date:** _____

BACK IN MOTION
ROBERT BENTLEY ARMANI, D.C., Q.M.E.
NICK AVEDIKIAN, D.C.

Patient's Name: _____

HIPPA RULES, REGULATIONS & LAWS

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.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer listed above.

TABLE OF CONTENTS

Thank you very much to take this time to review how we are carefully using your health information. If you have any questions we want to hear from you. If not we would appreciate it very much your acknowledgement of receiving of our HIPPA policy by signing and returning this HIPPA Policy package papers.

_____ _____
Patient Signature: Date:

RESCISSION OF ATTORNEY ASSIGNMENT OF BENEFITS

PATIENT:_____

INSURED: _____

DATE OF INJURY: _____

CLAIM#:_____

POLICY#: _____

SOCIAL SECURITY #: _____

I, being the insured on this policy, specifically direct you, my insurance company to rescind and cancel any assignment given to you by any third party including my attorney, EXCEPT to my physician listed below.

BACK IN MOTION
Robert Bentley Armani, D.C., O.M.E.
Nick Avedikian, D.C.,
14545 SYLVAN STREET, VAN NUYS, CA 91411
TEL: 818-782-2225 FAX 818-785-2225

As the owner and beneficiary of this policy, I further direct that reimbursement for ALL services be paid DIRECTLY to my physician, the provider of services, under the terms of my contract with this company. NO other third party, including my attorney, should receive payment of my medical bill for the remainder of this claim.

Thank you for your cooperation in this matter

_____ _____

Patient/Insured Signature **Date**

POWER OF ATTORNEY TO ENDORSE CHECKS

KNOW All MEN BY THESE PRESENT: That the undersigned has made, constituted and appointed, any these presents does hereby make, constitute and appoint the office of: ROBERT BENTLEY ARMANI / NICK AVEDIKIAN / BACK IN MOTION, and any of it's duly authorized agents and employees as and to be the undersigned's true and lawful Attorney In Fact for, and, in the undersigned name. place and stead to endorse any and all check, drafts, or money orders which are made payable to the undersigned alone or to the undersigned and the said offices of:

_____

_____

which checks drafts or money orders are to pay for Chiropractic services or the like which have been made by the office of:

_____

_____

at the request or within the knowledge and approval of the undersigned and/or the maker of the check, draft or money order.

The undersigned by these presents does thus give and grant unto the said office of

_____the full power and authority to do and perform all and every act and thing whatsoever requisite and necessary to be done in and about the premises as fully to all intents and purposes as the undersigned might or could do to personally present insofar as the endorsing and cashing of said check are concerned. The undersigned does hereby ratify and confirm any and all actions taken by the office

of _____as Attorney In Fact, in accordance with this special power of attorney and shall do or cause to be done by virtue of these presents.

IN WITNESS WHEREOF the undersigned have hereunto set their hands, this

_____DAY OF _____,20_____.

_____ _____

Signature of Patient **Patient's Full Name (Typed)**

_____ _____

Witness to Patient's Signature **Witness's Full Name (Typed)**

RESCISSION OF ATTORNEY ASSIGNMENT OF BENEFITS

PATIENT:_____

INSURED: _____

DATE OF INJURY: _____

CLAIM#:_____

POLICY#: _____

SOCIAL SECURITY #: _____

I, being the insured on this policy, specifically direct you, my insurance company to rescind and cancel any assignment given to you by any third party including my attorney, EXCEPT to my physician listed below.

BACK IN MOTION
ROBERT BENTLEY ARMANI, D.C., Q.M.E.
NICK AVEDIKIAN, D.C.
14545 SYLVAN STREET VAN NUYS, CA 91411
TEL: 818-782-2225 FAX: 818-785-2225

As the owner and beneficiary of this policy, I further direct that reimbursement for ALL services be paid DIRECTLY to my physician, the provider of services, under the terms of my contract with this company. NO other third party, including my attorney, should receive payment of my medical bill for the remainder of this claim.

Thank you for your cooperation in this matter

_____ _____

Patient/Insured Signature Date

WAIVER

I have been advised by BACK IN MOTION/DR. AVEDIKIAN and Drs. Dr. Robert Bentley Armani, D.C., Q.M.E. that in order to properly diagnose my condition, I should submit to the following procedure(s):

_____
_____
_____
_____
_____
_____

I, knowing that the doctor cannot properly diagnose my condition without such procedures, hereby agree and request that treatment be rendered to me, without submitting to the above mentioned procedures, despite having been informed that said treatment might be injurious to my condition. In the event my condition deteriorates or is aggravated as a result of my refusal to submit to such examination procedures recommended above, I will hold BACK IN MOTION Drs., Dr. Robert Bentley Armani, D.C., Q.M.E., DR. AVEDIKIAN harmless because of my failure to submit to such recommended examination procedures.

Signed: _____ Date: _____

Witnessed _____ Date: _____

Assignment & Instruction For
Direct payment To Doctor

Patient Name: _____

Address: _____

Attorney: _____

Employer: _____

Claim or Group # SS# or ID#: _____

I hereby instruct the above named Insurance Company to pay by check made out to and mailed directly to:

BACK IN MOTION
ROBERT BENTLEY ARMANI, D.C., Q.M.E.
NICK AVEDIKIAN, D.C.
14545 SYLVAN STREET VAN NUYS, CA 91411
TEL: 818-782-2225 FAX: 818-785-2225

If my current policy prohibits direct payment to the doctor, then I hereby instruct and direct you to make out the check to me and mail it as follows:
C/O

BACK IN MOTION
ROBERT BENTLEY ARMANI, D.C., Q.M.E.
NICK AVEDIKIAN, D.C.
14545 SYLVAN STREET VAN NUYS, CA 91411
TEL: 818-782-2225 FAX: 818-785-2225

for professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. 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 fees for non-covered services and for fees, over and above the insurance payment or as required by my insurance policy. A photocopy of this Assignment shall be considered as effective and valid as the original. I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney for the purpose of securing payment under this policy of insurance.

Dated at _____ County, this day of _____ 20____.

_____ _____
Signature of Policy Holder Witness

_____
Signature of Claimant, if other than Policyholder

BACK IN MOTION

Robert Bentley Armani, D.C., Q.M.E. **Nick Avedikian, D.C.**
14545 SYLVAN STREET, VAN NUYS, CA 91411
TEL: 818-782-2225 FAX 818-785-2225

Patient's Name: _____

DOB: _____

I hereby authorize and give consent to being photographed by Dr. Robert Bentley Armani and/or BACK IN MOTION and/or his assistants/staff. I understand that this photograph is used in connection with my personal injury case and file for med legal purposes. BACK IN MOTION / Dr. Robert Bentley Armani, D.C., Q.M.E. and his staff are fully authorized to take my picture/photograph.

Print The Patient's Name: _____ **Date:** _____

Signature of The Patient: _____ **Date:** _____

Signature of Patient's Representative: _____ **Date:** _____

Witness to Patient's Signature: _____ **Date:** _____

Translated By: _____ **Date:** _____

Third Party Medical Lien And Assignment

PATIENT: _____

CLAIM #: _____

DATE OF INJURY: _____

I hereby authorize and direct _____ Insurance Company, to pay to BACK IN MOTION / ROBERT BENTLEY ARMANI, D.C., Q.M.E. such sums as may be due and owing him/her for medical/chiropractic services rendered me by reason of the accident and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect and fully compensate said doctor. And I hereby further request that payment be made directly to said doctor which would otherwise be paid to myself, as the result of the treatment charges injured for injuries in connection therewith. This is a direct assignment of my rights and benefits under This claim. I fully understand that I am directly and fully responsible to said doctor for all medical bill submitted by him for services rendered me and that this agreement is made solely for said doctor's protection and in consideration of his awaiting payment. And I further understand that such payments are not contingent on any settlement, judgment or verdict which I may eventually recover.

Please acknowledge your agreement to this request by signing below and returning to the doctor's office below. I have been advised that if you do not wish to cooperate in protecting the doctor's interest, the doctor will not await payment, but may declare the entire balance due and payable by me.

Date: _____ **Patient's Signature:** _____

The undersigned Insurance company 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 and fully compensate said doctor above and below named and make payment payable directly to said doctor.

Date: _____

_____

Signature of Insurance Company Representative

_____

Print First and Last Name

_____

Insurance Company Name

Please date, sign and return one copy to the doctors office below.

BACK IN MOTION

ROBERT BENTLEY ARMANI, D.C., Q.M.E.
NICK AVEDIKIAN, D.C.
14545 SYLVAN STREET VAN NUYS, CA 91411
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BACK IN MOTION

Robert Bentley Armani, D.C., Q.M.E. **Nick Avedikian, D.C.**
14545 SYLVAN STREET, VAN NUYS, CA 91411
TEL: 818-782-2225 FAX 818-785-2225

Financial Agreement - Personal Injury

We would like to take a moment to welcome you to our office and to assure you that you will receive the very best care available for your injury. In order to familiarize you with the financial policy of our office, I would like to explain how your medical/chiropractic bills will be handled.

PARTY RESPONSIBLE: If you were involved in an auto accident in your own vehicle, we will bill the medical payments portion or Personal Injury Protection portion of your insurance policy to cover the treatment charges incurred in our office.

MED PAY: If you were a passenger in another vehicle, the insurance company which insures the automobile may be billed. for your medical services incurred PIP if you were a passenger in another vehicle, and you own a car which has PIP coverage, the insurance company which carries your policy will be responsible to pay your medical bills.

3rd PARTY: If another vehicle has caused the accident, we will first bid your automobile Med-Pay or PIP policy for coverage PRIOR to submitting a claim to the insurance carrier of the party at fault. It is also to your advantage for our office to bill your own health insurance policy for your medical services, providing your policy does not state otherwise. Any amount received above and beyond your total bill in this office will be refunded to you

ATTORNEY LIENS: If you hire an attorney to represent you in a law suit, it is our policy to have your attorney sign a Doctors Lien. This will guarantee direct payment to our office for any undid balance upon the settlement of your law suit. We retain the right; to first submit all charges to your private and/or auto insurance policy for payment. Further, this office does not discount or reduce the amount of your balance based upon the outcome of your settlement.

RESPONSIBILITY FOR PAYMENT: As a courtesy to you, we will gladly submit your charges to your insurance company(ies) and/or your attorney; however, all services rendered by this office are charged directly to you, and ultimately, you are personally responsible for payment of these charges, regardless of any insurance reimbursement or settlement you may or may not receive.

Once again, we welcome you to our office. We hope that this has answered any questions that you might have about our financial arrangements. If, at any time, you have further questions about your care, please, don't hesitate to ask.

I have read and agree to the above:

_____ _____

Patient's Signature **Date**

Back In Motion Chiropractic
14545 Sylvan St.
Van Nuys, CA. 91401
Tel.: (818) 782-2225 Fax: (818) 785-2225

NOTICE OF DOCTOR'S LIEN

Patient: _____ **Date of Accident:** _____

I do hereby authorize Dr. N. Avedikian & Dr. Robert B. Armani 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 recently involved.

I hereby authorize and direct you, my attorney, to pay directly to said doctors such sums as may be due and owing them for the medical service rendered me both by reason of this accident and by reason 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 and fully compensate said doctors. And I hereby further give a lien on my case to said doctors against any and all proceeds of my 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 fully understand that I am directly and fully responsible to said doctors for all medical bills submitted by them for service rendered me and that this agreement is made solely for said doctor's additional protection and in consideration of them 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.

I agree to promptly notify said doctors of any change or addition of attorney(s) used by me in connection with this accident, and I instruct my attorney to do the same and to promptly deliver a copy of this lien to any such substituted attorney(s).

Please acknowledge this letter by signing below and returning to the doctor's office. I have advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctors will not await payment and may declare the entire balance due and payable.

_____ _____
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 and fully compensate said doctors above-named. Attorney further agrees that in the event this lien is litigated, that the prevailing party will be awarded attorney fees and costs.

_____ _____
Firm Name **Attorney's Name**

_____ _____
Date **Attorney's Signature**

Back In Motion Chiropractic
14545 Sylvan St.
Van Nuys, CA. 91401
Tel.: (818) 782-2225 Fax: (818) 785-2225

NOTICE OF DOCTOR'S LIEN

Patient: _____ **Date of Accident:** _____

I do hereby authorize Dr. N. Avedikian & Dr. Robert B. Armani 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 recently involved.

I hereby authorize and direct you, my attorney, to pay directly to said doctors such sums as may be due and owing them for the medical service rendered me both by reason of this accident and by reason 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 and fully compensate said doctors. And I hereby further give a lien on my case to said doctors against any and all proceeds of my 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 fully understand that I am directly and fully responsible to said doctors for all medical bills submitted by them for service rendered me and that this agreement is made solely for said doctor's additional protection and in consideration of them 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.

I agree to promptly notify said doctors of any change or addition of attorney(s) used by me in connection with this accident, and I instruct my attorney to do the same and to promptly deliver a copy of this lien to any such substituted attorney(s).

Please acknowledge this letter by signing below and returning to the doctor's office. I have advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctors will not await payment and may declare the entire balance due and payable.

_____ _____
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 and fully compensate said doctors above-named. Attorney further agrees that in the event this lien is litigated, that the prevailing party will be awarded attorney fees and costs.

_____ _____
Firm Name **Attorney's Name**

_____ _____
Date **Attorney's Signature**

BACK IN MOTION

Robert Bentley Armani, D.C., Q.M.E. **Nick Avedikian, D.C.**
14545 SYLVAN STREET, VAN NUYS, CA 91411
TEL: 818-782-2225 FAX 818-785-2225

SPECIAL INSTRUTIONS TO MY ATTORNEY REGARDING DOCTOR'S LIEN

Date: _____

Patient's Name: _____ DOI: _____

To my attorney of the record:

Dear attorney _____,

I hereby request and instruct you as your client to honor Dr. ROBERT BENTLEY ARMANI, D.C., Q.M.E.'s /BACK IN MOTION'S lien on my case with the date of injury: _____.

In an even that I change attorneys, I hereby request and instruct **my new attorney (s)** to honor Dr. ROBERT BENTLEY ARMANI, D.C./BACK IN MOTION's lien on my case, unconditionally,

with the date of injury: _____ . Once again, it is very important that you honor the lien of Dr. ROBERT BENTLEY ARMANI, D.C., Q.M.E./BACK IN MOTION. on My case so that he may fully and properly be compensated for the services that he rendered to me due to my injuries. As my attorney you must honor Dr. ROBERT BENTLEY ARMANI, D.C., Q.M.E.'s ./ BACK IN MOTION'S lien whether you signed or did not sign his lien. Also, this is to further instruct you, that, as my attorney you must fully cooperate with Dr. ROBERT BENTLEY ARMANI, D.C., Q.M.E./BACK IN MOTION and their office with regards to answering all of Dr. ROBERT BENTLEY ARMANI, D.C., Q.M.E.'s ./BACK IN MOTION. questions regarding my case, giving prompt status and information on my case any time ROBERT BENTLEY ARMANI, D.C., Q.M.E. ./ BACK IN MOTION. asks you or your office, have a full and open line of communication with Dr. ROBERT BENTLEY ARMANI, D.C., Q.M.E.'s ./ BACK IN MOTION office regarding my case, forward a copy of my insurance and the other party's insurance information and claim number to Dr. ROBERT BENTLEY ARMANI, D.C., Q.M.E./ BACK IN MOTION. and his office. Once the case (my case) settled let Dr. ROBERT BENTLEY ARMANI, D.C., Q.M.E./BACK IN MOTION. and his office know promptly and notify Dr. ROBERT BENTLEY ARMANI, D.C., Q.M.E. /BACK IN MOTION. and his office promptly of the details of my case and full and complete amount of settlement. This is an irrevocable instruction to you as my attorney a copy shall be considered as original. This instruction shall be valid indefinitely and/or you have properly and fully cooperated and satisfied Dr. ROBERT BENTLEY ARMANI, D.C., Q.M.E../ BACK IN MOTION. Lien on my case. I hereby sign this letter with my full consent and approval.

_____ _____

Dated **PATIENT'S SIGNATURE**