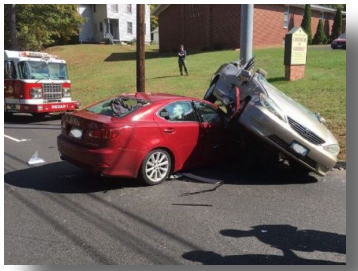
T. STEVEN QUACH M.D..: American Board Anesthesiology & Pain Management
STEPHEN B. COOPER, D.C.: Licensed in AL and GA. MUA Certified
ALICIA REED, F-N.P.
Juliet Gumbs DNAP CRNA



DATE: _____

NAME:_____ DATE OF ACCIDENT: _____

ADDRESS: _____ CITY: _____ STATE :_____ ZIP: _____

CELL#: _____ HOME #: _____ WORK: _____

CELL PHONE CARRIER: _____ RACE: _____ ETHNICITY : _____ HISPANIC _____ NON-HISPANIC

DOB: _____ AGE: _____ SSN: _____

EMPLOYER : _____ OCCUPATION: _____WK.PHONE:_____

EMAIL (USED FOR PATIENT RECORDS AND OFFICE COMMUNICATION) _____

MARITAL STATUS: M S D W _____ SPOUSE NAME: _____

INSURANCE INFORMATION : PLEASE GIVE COPY OF ALL INSURANCE CARDS AND DRIVERS LICENSE/ID TO FRONT DESK

NAME OF HEALTH INSURER: _____PRIMARY CARE PROVIDER: _____ ___ NONE

POLICY #: _____ GROUP#: _____ PHONE#: _____

NAME OF AUTO INSURANCE CARRIER: _____ ____NONE

AUTO POLICY # _____ ADJUSTER _____

PHONE NUMBER: _____ KNOWN MEDPAY LIMITS? _____

IF INSURANCE IN ANOTHER'S NAME: _____ DOB: _____ SSN: _____

Name of Medication	Dosage/Strength	Frequency	Date started/stopped

Known Allergies	

EMERGENCY CONTACT INFORMATION

NAME: _____ **RELATIONSHIP**_____
PHONE: _____ **RELATIONSHIP**_____-
NAME: _____ **RELATIONSHIP**_____-
PHONE: _____ **RELATIONSHIP**_____
INITIAL HERE IF YOU WANT THEM TO HAVE ACCESS TO INFORMATION ABOUT YOUR PRESENCE IN THE CLINIC

I,_____(Print Name), do hereby authorize Dr. Stephen B. Cooper, Dr. Lynne Lofton and Dr. Sean Lauraitis and whomever he may designate as his assistants to perform diagnostic tests, including but not limited to radiographs, physical examination and administer treatment as directed, indicated or deemed necessary. This includes emergency actions that may need to be performed should I be physically incapacitated. Complications to chiropractic care may include rib fracture and stroke, however, specific tests designed to minimize these risks are employed and do minimize these outcomes. I ALSO CERTIFY THAT IN NO WAY HAS ANY GUARANTEE OR ASSURANCES AS TO THE RESULTS THAT MAY BE OBTAINED.

I understand and agree that health and medical insurance policies are an arrangement between an insurance carrier and myself (patient). Furthermore, I understand and agree that this office and contracted representatives may prepare or receive any necessary reports and forms to assist me in making collection from the insurance company, and that any amount authorized to be paid and sent directly to this office will be credited to my account upon receipt. I permit this office to endorse remittances for the conveyance of credit to my

NAME (PRINTED): _____ **SIGNED:** _____**DATE:**_____

WITNESS (PRINTED): _____ **SIGNED:** _____**DATE:**_____

Consent for Treatment of a Minor

I hereby authorize the Phenix City Spine & Joint Center, LLC, Dr. Stephen B. Cooper, Dr. Lynne Lofton and Dr. Sean Lauraitis and whomever they may designate as an associate or contractor of this clinic to perform diagnostic tests, radiographic studies, physical evaluations, and to administer treatment as he deems necessary to__, a minor child under my guardianship. I also accept all terms and conditions named herein with regards to payment of the account and lien arrangements and am responsible for the execution of these agreements on this minors behalf.

GUARDIAN PRINTED NAME: _____ **SIGNED** _____ **DATE:**_____

GUARDIAN DOB: _____ **SSN:** _____

WITNESS PRINTED NAME: _____ **SIGNED** _____ **DATE:**_____

DATE OF ACCIDENT & TIME OF ACCIDENT		**WHAT DIRECTION WERE YOU FACING? (FORWARD, TO THE RIGHT ETC..)**		**WHERE DID IT HIT (HEAD ON , REAR - T-BONE ETC)**	
LOCATION OF ACCIDENT		**WERE YOU WEARING A SEAT BELT?**		**WERE YOU READY FOR IMPACT (WAS THERE TIME TO BRACE)**	
CITY/STATE OF ACCIDENT		**WHAT WERE YOU DRIVING**		**WAS IT A HIT AND RUN**	
WERE YOU DRIVING, PASSENGER AND WHERE IN VEHICLE?		**WHAT TYPE OF VEHICLE HIT YOU**		**DID YOUR SEAT BREAK**	

IT HELPS US TO HELP YOU IF YOU CAN BE VERY THOROUGH AND COMPLETE, FEEL FREE TO ASK FOR HELP, CIRCLE ALL OF THE FOLLOWING THAT APPLY

DID THE AIRBAG DEPLOY?	**THE VEHICLE FLIPPED OVER**	**THE REAR WINDOW BUSTED**	**I WAS UNAWARE THE COLLISION WAS ABOUT TO HAPPEN**
I GOT BURNS FROM THE AIRBAG	**THE VEHICLE RAN OFF THE ROAD**	**THE DRIVERS SIDE WINDOW BROKE**	**I WAS TAKEN TO THE HOSPITAL BY AMBULANCE**
I WAS THROWN FROM THE CAR	**THE VEHICLE WAS PUSHED INTO ANOTHER CAR**	**THE PASSENGERS WINDOW BROKE**	**I WAS TAKEN TO THE HOSPITAL BY PRIVATE CAR**
I DONT REMEMBER THE ACCIDENT - I WAS UNCONSCIOUS	**THE VEHICLE SLID INTO A DITCH**	**THE FRONT WINDSHIELD BURST**	_____
THE VEHICLE WAS HIT BY ANOTHER CAR	**THE VEHICLE WAS TOTALED**	**DID THE VEHICLE SPIN AROUND**	_____

PLEASE DETAIL ANY OTHER FACTS ABOUT YOUR ACCIDENT WE DON'T KNOW:

_____

_____

_____

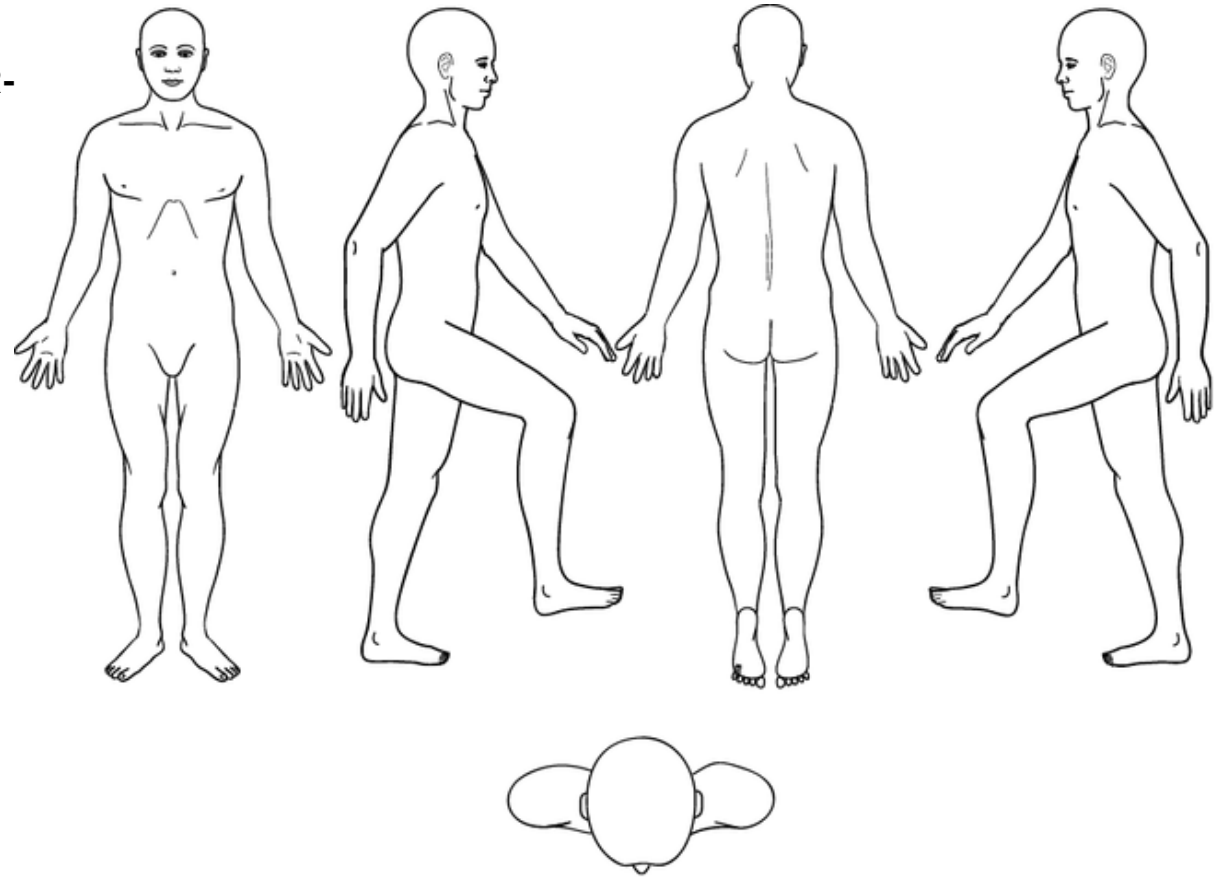
IF YOU WENT TO THE HOSPITAL, WHICH ONE AND WHAT HAPPENED THERE?

HOSPITAL? _____ CITY/STATE:_____

CIRCLE WHAT APPLIES TO YOUR HOSPITAL VISIT: EXAMINED X-RAYED (HEAD, NECK , BACK , SHOULDER, ARM, HIP, KNEE, _____) MRI CT (HEAD, NECK , BACK , SHOULDER, ARM, HIP, KNEE, _____) SURGERY STITCHES (HOW MANY AND WHERE _____) SHOT IV MEDICATION SCRIPT FOR ADDITIONAL MEDICATION, OTHER: _____

_____

PLEASE MARK EVERY AREA USING THE KEY BELOW. YOU CAN USE ARROWS TO SHOW SHOOTING PAIN AND NUMBERING 1 THROUGH 6 TO SHOW THE MOST SIGNIFICANT AREAS



B = BURNING
S = SHOOTING
X = PAIN
V = SEVERE PAIN
D = DULL PAIN
N = NUMBNESS
W = WEAKNESS

PAST HEALTH HISTORY: IF YES LIST IN ADJACENT BOX

HAVE YOU BEEN INVOLVED IN AN AUTO ACCIDENT PRIOR TO THIS ONE Y N

ARE YOU PREGNANT Y N

HAVE YOU HAD PREVIOUS HOSPITALIZATIONS Y N

HAVE YOU HAD ANY PRIOR SURGERIES Y N

HOSPITALIZATIONS/SURGERIES PREVIOUS ACCIDENTS AND OTHER MEDICAL HISTORY:

_____

_____

_____

_____

REVIEW OF SYSTEMS								
CONSTITUTIONAL	ALCOHOLISM	DIZZINESS	CHEMICAL DEPENDENCY	HISTORY OF DIABETES	FEVER / NIGHT SWEATS	HISTORY OF CHRONIC FATIGUE	NUTRITION PROBLEMS	UNEXPLAINED WEIGHT CHANGE
EENT	CATARACT	GLAUCOMA	COLOR BLINDNESS	MOTION SICKNESS	NIGHT BLINDNESS	BLURRY VISION	EPISTAXIS / NOSE BLEEDS	SEVERE SINUS
RESPIRATORY	ASTHMA	BRONCHITIS	EMPHYSEMA	INFLUENZA	PLEURISY	PNEUMONIA	TUBERCULOSIS	
CARDIOVASCULAR	HEART ATTACK	HEART DISEASE	HEART MURMURS	HIGH CHOLESTEROL	HBP	IRREGULAR HEART BEAT	CHEST PAIN / DISCOMFORT	SHORTNESS OF BREATH
GENITOURINARY	BLADDER PROBLEMS	CYSTITIS	GALL BLADDER DISEASE	KIDNEY DISEASE	KIDNEY STONES	NEPHRITIS	PROSTATE PROBLEMS	VAGINAL INFECTIONS, VENEREAL DISEASE
MUSCULO SKELETAL	ARTHRITIS	GOUT	OSTEOPOROSIS	JOINT DEFORMITY	BONE & JOINT DISEASE	MULTIPLE SCLEROSIS	HERNIATED DISC	POSTURAL PROBLEMS - SCOLIOSIS
NEUROLOGICAL	FACIAL WEAKNESS	EQUILIBRIUM DISTURBANCE	DYSPHAGIA - DIFFICULTY EATING	HEARING DISTURBANCES	SPEECH - SWALLOWING OR TASTE PROBLEMS	EPILEPSY	BLACKOUTS OR MEMORY LOSS	VERTIGO
HEMATOLOGIC / LYMPHATIC	ANEMIA	HEPATITIS	HIV	LYMPHATIC MALIGNANCY	BLEEDING SKIN	SWOLLEN LYMPH NODES	SICKLE CELL	HISTORY OF MUMPS
INTEGUMENT	BRUISING	COLOR CHANGE	DRY SKIN	EDEMA / SWELLING	ITCHING	LESIONS	RASH	SKIN CANCER

ASSIGNMENT OF BENEFITS: I HEREBY AUTHORIZE THE FOLLOWING INSURANCE COMPANIES OR LIABLE DIRECT PAY PARTIES:

1. _____
2. _____
3. _____
4. _____

to pay by check or credit card through either mailing the check payable to Phenix City Spine & Joint Center—P.O. Box 1611 Phenix City, AL 36867. or Forest Park Spine & Joint Center — P.O. Box 1601 Phenix City AL, 36867 This covers the expense benefits allowable and otherwise payable to me under my current policy, as payment towards the total charges for professional services rendered I have agreed to pay, in a current manner, any balance of said applicable charges. I further state and agree that this office is given a limited power of attorney to endorse / sign my name on any and all drafts directed for the payment of my bill.

PATIENT PRINTED NAME: _____ SIGNED _____ DATE:_____

WITNESS PRINTED NAME: _____ SIGNED _____ DATE:_____

HOW DID YOU HEAR ABOUT THIS OFFICE:

_____

IF YOU HAVE AN ATTORNEY COMPLETE THE FOLLOWING:

ATTY NAME: _____ **FIRM:** _____

CASE MANAGER: _____ **PHONE:** _____

EMAIL ADDRESS: _____

Date of Injury:_____**Policy / Claim #** _____ **Contract for Services including the LIEN AGREEMENT**

This document and all that is contained herein is a specifically designed instrument to detail an irrevocable assignment, enforceable contract and lien. This contract and lien is entered into between the South Atlanta MUA Center, LLC & our appointed counselor. (print patient's or guardian name clearly) _____here forth known as "patient" and (print attorney/insurance company)_____here forth known as the "attorney" and/or "insurance company" and is binding on these listed parties for the following text. The patient hereby directs the attorney or insurance company that for any balance such as may be due owing to this office for services rendered to the patient to withhold such funds from any disability benefits, medical payment benefits, health and accident benefits, medical or personal injury settlements or any such other insurance benefit obligated to reimburse the patient, or from any settlement, judgment or verdict on my behalf as may be necessary to adequately satisfy any balance owing and protect the interest of the South Atlanta MUA Center, LLC

I further irrevocably authorize this clinic to obtain a perfected lien attaching any and all insurance benefits, judgments, and settlements named herein. Once I have accepted terms and or conditions or made an agreement with any third party for any amount relating to this injury or claim, this document is to serve as an irrevocable assignment and lien of these benefits or proceeds of the agreement or settlement to the amount necessary to adequately satisfy any balance owing and protect the interests of the South Atlanta MUA Center, LLC.

If there is an attorney representing me, this lien against me is to be enforced against the third party insurance company for direct payment or payment through the attorney at the discretion of the clinic. If the clinic at it's discretion does allow payment from the attorney, the patient is bound personally and jointly with the attorney, if retained, or other noted counsel responsible for the total amounts due to said office. The attorney is only released from this binding lien if there is no settlement of any amount for the above mentioned injury or: if the patient acquires new counsel the contract is now binding on the new counsel in its entirety, and if all

legal representation in reference to this accident has been terminated prior to the settlement with the previous attorney, the previous attorney mentioned in this document is therefore released from all aspects of this contract upon written notice received in this office by US Mail according to the post marked date. The patient and attorney understand that not honoring the full extent and purpose of this contract constitutes default and binds upon both parties separately and individually all charges, collection costs, attorney fees and finance charges. This contract can only be altered with the amount of settlement by written signed verification from the South Atlanta MUA Center, LLC and the bound third party or attorney.

PATIENT PRINTED NAME: _____ **SIGNED** _____ **DATE:**_____

WITNESS PRINTED NAME: _____ **SIGNED** _____ **DATE:**_____

ATTORNEY PRINTED NAME: _____ **SIGNED** _____ **DATE:**_____

INS ADJUSTER PRINTED NAME: _____ **COMPANY** _____ **DATE:**_____

I authorize this clinic to release or receive any information pertinent to this injury to or from the attorney and to or from any insurance company or responsible third party attorney or adjuster to facilitate collection under this assignment and contract. The clinic may perfect an AL or GA lien or obtain a letter of protection from any attorney representing me in this case.

HIPAA PRIVACY Statement for the PHENIX CITY SPINE & JOINT CENTER

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

Understanding your health record information

Each time you visit a hospital, physician or other health care provider, a record ofyour visit is made. Typically this record contains your symptoms, examination, test results, diagnosis, treatment and a plan for future care and treatment. This information is often referred to as your health and medical record and serves as, but not limited to the following:

◊ A basis for planning your care and treatment

◊ Means of communication along the many health professionals who contribute to your care

◊ Legal documentation describing the care you received

◊ Means by which your third party payer can verify that services billed were actually provided

◊ A tool in educating health care providers

◊ A source of date for medical research

◊ A tool we utilize to assess, analyze and improve the care we render and the outcomes we have achieved.

This Information is shared with you to help you:

◊ Ensure its accuracy

◊ Understand who and under what circumstances they may access your health information

◊ Make a more informed decision when signing disclosure statements to authorize access by others.

Your Health Information Rights

Although your health record is the physical property of the health care provider or the facility who compiled it, the information belongs to you. You have the right to:

◊ Request a restriction on certain uses and disclosures of your information as provided by CFR 164.522

◊ Obtain a paper copy of notice of information practices upon request

◊ Inspect and copy your health record as provided in 45 CFR 164.524

◊ Obtain an account of the disclosures of your health record

◊ Revoke authorization for future disclosure except that which has already been provided

Our Responsibilities:

◊ Maintain privacy of your health information

◊ Provide you with notice as to our legal duties and privacy practices with respect to infor- mation we collect and maintain about you

◊ Abide by all the terms of this notice

◊ Notify you if we are unable to agree to a requested restriction

◊ Accommodate reasonable requests you may have to communicate health information by alternative means to alternative locations

We reserve the right to change our practices and make new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you have supplied to us.

We will not use or disclose your health information without your authorization, except as described in this notice.

For more information, questions, or to report a problem, you may contact our HIPAA Privacy Officer at (412) 446-9100. If you believe your privacy rights have been violated, you may file a complaint with our HIPAA Privacy Officer. There will be no retaliation for filing a complaint.

I have read the HIPAA PRIVACY STATEMENT and Understand: _

_____

Initial (HIPAA stands for the “health insurance portability and accountability act”)

I, , hereby authorize SOUTH ATLANTA MUA CENTER, LLC: 541 FOREST PARKWAY, FOREST PARK GA 30297: , its agents/employees, as well as its counsel, Richard L. Cross, Jr., Cross Law Firm, its agents/employees to investigate the existence of insurance coverage relating to that injury sustained on and being more specifically identified as follows: I understand that SOUTH ATLANTA MUA CENTER, LLC will need to reveal the minimal amount of information it deems necessary to Cross Law Firm to cause this investigation. Generally, this will be limited to wreck report and existence of injury associated with such applicable insurance coverage.I understand Cross Law Firm and/or SOUTH ATLANTA MUA CENTER, LLC, may need to disclose some or all of the information authorized herein to applicable insurance company and/or purported tort feasor/applicable third party (as is deemed by SOUTH ATLANTA MUA CENTER, LLC AND Cross Law Firm to be necessary to ascertain existence of applicable insurance coverage).

I hereby authorize SOUTH ATLANTA MUA CENTER, LLC and Cross Law Firm to make all such necessary disclosures, as they deem necessary to ascertain existence of insurance coverage. I agree to hold SOUTH ATLANTA MUA CENTER, LLC its agents/employees and Cross Law Firm, including its agents/employees as well as associated medical/legal professionals for any loss I may suffer as a result. I have been advised of my opportunity to discuss/have this authorization reviewed by independent counsel before executing the same. I have either obtained indepen-dent legal counsel's opinion and agree to this Authorization or hereby waive my right to the same and agree to this Authorization. 1have read and understood the terms and ramifications outlined herein. I voluntarily accept the same.

I understand Cross Law Firm does not represent me in this Authorization or action authorized herein. Cross Law Firm

And associated legal professionals are counsel of SOUTH ATLANTA MUA CENTER, LLC and will be acting in SOUTH ATLANTA MUA CENTER's best interest. Benefit to me is and shall be

deemed incidental to any action taken by Cross Law Firm seeking coverage or serving Phenix City Spine & Joint. I understand

that I am solely responsible for my debt to SOUTH ATLANTA MUA CENTER, LLC for services/treatment rendered and shall pay/cause payment of the same. Signed this day of , 20__

PATIENT PRINTED NAME: _____ **SIGNED** _____ **DATE:**_____

WITNESS PRINTED NAME: _____ **SIGNED** _____

DATE:_____

SOUTH ATLANTA MUA CENTER, LLC 541 FOREST PARKWAY, FOREST PARK GA 30297: 404.261.9011: WWW.CHIMEDMUA.COM

T. STEVEN QUACH M.D..: American Board Anesthesiology & Pain Management
STEPHEN B. COOPER, D.C.: Licensed in AL and GA. MUA Certified
ALICIA REED, F-N.P.
Juliet Gumbs DNAP CRNA

THIS IS A FORMAL REQUEST FOR MEDICAL RECORDS, X-RAY'S, MRI'S, LAB TESTS AND REPORTS BE SENT TO

___ SOUTH ATLANTA MUA CENTER, TO THE ABOVE ADDRESS OR FAXED TO: 877.292.4848

REGARDING THE PATIENT: _____

SOCIAL SECURITY NUMBER _____ BIRTH DATE _____

PLEASE SEND RECORDS BY THIS DATE: _____

PATIENTS SIGNATURE FOR RELEASE:

_____ _____

PATIENT'S SIGNATURE **TODAY'S DATE**
(REQUEST EXPIRES 30 DAYS FROM THIS DATE)

IF YOU HAVE ANY QUESTIONS, PLEASE CALL US. WE APPRECIATE YOUR PROMPTNESS FOR THIS REQUEST.

THANK YOU, SOUTH ATLANTA MUA CENTER, LLC