WEST MICHIGAN CHROPRACTIC CENTER, P.L.C.

By signing below, I acknowledge that I have received a copy of the Notice of Privacy for Protected Health Information and Consent for Use or Disclosure of Health Information, currently in use by West Michigan Chiropractic Center, P.L.C. This authorization will expire seven years after the date on which you last received services from us. This notice is effective as of 12/31/02.

_____ _____

Patient Name Printed Date

_____

Patient Signature

_____

Personal Representative Printed

_____

Personal Representative Signature

_____

Description of personal representative's authority to act for the patient.

WEST MICHIGAN CHIROPRACTIC CENTER, P.L.C.

6475 BELDING RD NE, ROCKFORD, MI 49341

Treatment Consent and Payment Agreement

In consideration for the services rendered to me by West Michigan Chiropractic Center, PLC (WMCC), I hereby execute this Treatment Consent and Payment Agreement ("Agreement") and agree to the following:

CONSENT FOR TREATMENT: knowing that I desire (or the patient for whom I am signing desires) chiropractic treatment from WMCC, I do hereby voluntarily consent to such treatment by West Michigan Chiropractic staff and employees as deemed necessary in their judgment to my chiropractic care and understand the risk when accepting care which can include, but is not limited to, musculoskeletal injury, stroke, or arterial dissection.

NO REPRESENTATIONS OR GUARANTEES: I am aware that the chiropractic treatment is not an exact science and I acknowledge that no oral or written representations, guarantees or promises have been made to me as to the results of any treatment and care that I (or patient) may receive from WMCC. I am aware that compliance with any treatment program designed by WMCC is essential to my (or the patient's) successful treatment. I understand that additional treatments may be necessary if I (or the patient) do not adhere to the prescribed treatment schedule, fail to cooperate in treatment, fail to follow exercise recommendations, or engage in activity outlined to be injurious or which causes additional trauma to the body.

RELEASE OF INFORMATION: I hereby authorize WMCC to release any information about my treatment or physical condition to any person involved in my medical or chiropractic care and any third party responsible for paying for my care, including, without limitation, records relative to claims, my employer, and any workers compensation insurance carrier engaged by my employer and to any outside peer review or auditing agency engaged in third party payer to review my medical records. WMCC may also give information to Michigan Blue Cross/Blue Shield, Medicare, Medicaid, OCHAMPUS, or any other third party who may be responsible for payment of my account. WMCC may release my chiropractic records to any collection agency or attorneys it has engaged to collect any amounts due for services it has provided to me and I agree that those collection agencies or attorneys may introduce my chiropractic records as necessary in any court action to collect any amounts due for effect as long as is necessary to effectuate the purposes for which it is given.

ASSIGNMENT OF INSURANCE BENEFITS: I assign to WMCC all rights to benefits, insurance proceeds, settlement payments, or judgments to which I may be entitled for WMCC's services. I also give WMCC the right to intervene in any lawsuit or other action brought by me, or on my behalf, to collect amounts due to WMCC for services rendered to me. If I have (or the patient for whom I am signing has) insurance through Michigan Blue Cross/Blue Shield, Medicare, Medicaid, OCHAMPUS, or any third party, or an automobile no fault carrier, I agree that I want WMCC to bill my insurance directly and request that any payment for insurance be made directly to WMCC. I certify that the insurance information given by me is correct. I understand that I am responsible for any balance not paid by insurance.

PAYMENT AND GUARANTY AGREEMENT: I agree to the following:

a) In consideration for the services to be rendered by WMCC to the Patient and the Patient's representative or agent shall both be personally obligated to pay for such services in accordance with WMCC's standard rates, irrespective of whether the undersigned signs as Patient or the Patient's representative or agent. Either the Patient or the Patient's representative or agent must pay all the amounts not paid by Insurance.

b) Payment is due in full after WMCC deposits in the mail the first bill to the Patient or the Patient's representative or agent. If the outstanding bill is not paid within 30 days after mailing the first bill, the account will be considered delinquent and a late payment charge of 0.5% per month (6% per annum) will be added to the unpaid balance 30 days after the first billing and every 30 days thereafter.

c) In the event that the account is turned over to an attorney or collection agency for collection, the Patient or the Patients representative or agent shall pay all reasonable collection costs including attorney fees incurred by WMCC.

d) The signature of the Patient's representative or agent does not relieve the Patient from his or her obligation to pay for services rendered.

e) In consideration for payments that have been paid in advance for treatments not yet received, that WMCC will refund such payments within (30) thirty days of written notice from the Patient or the Patient's representative or agent.

MISCELLANEOUS: Where "I" is used in this agreement, it refers to both the Patient and the Patient's representative or agent. I understand that WMCC has no duty to investigate the authority of the Patient's representative or agent and is relying on the representation of the Patient's representative or agent that he or she has the authority required to enter into this agreement.

MASSAGE: Cancelation policy: In the event that you cancel with less than 24 hours from the time of your massage appointment and/ if you do not attend your massage without notice, there will be a charge for half of the cost of your massage. If you arrive late for your massage, the amount of time for your massage will be decreased proportionately based on what time your arrived.

I UNDERSTAND THAT ANY AMOUNTS NOT PAID BY MY INSURANCE ARE MY RESPONSIBILITY.

By signing below, I acknowledge that I have read, understand and agree to the terms of this West Michigan Chiropractic Center, PLC Treatment Consent and Payment Agreement.

Printed Patient Name _____ Relationship (if other than Patient) _____ Date _____

Signature of Patient or Patient's representative or agent _____

Signature of West Michigan Chiropractic Center staff _____

West Michigan Chiropractic Center P.L.C.
Pediatric Form

(Please fully complete questionnaire to the best of your knowledge by printing or circling information as needed)

Today's Date: ____/____/_____

Name: _____ Preferred name: _____
First MI Last

D.O.B: ____/_____/_____ Sex: M F

Patient's Parents/ Guardian: _____

Phone: (____)_____ Who is responsible for this account?_____

Address: _____

City: _____ State: _____ Zip: _____

Is the child covered by any health insurance? Yes or No
Will you be billing insurance? Yes or No

Email: _____ **Would you like your statements emailed?** Yes or No

Primary Insurance holder's Name: _____

Primary Insurance holder's D.O.B.: ____/_____/_____

How did you hear about our office: _____

Reason for office visit: Wellness or Health Concern

If concern, what is the primary reason for your visit? (Please describe and include any specific symptoms):_____
_____

Please check any of the following your child has experienced and list the frequency of occurrence of the child's complaint or symptoms per day, week, month or year.

# Times	#Times	#Times
____ ear infections	____ chronic colds	____ fevers
____ asthma attacks	____ digestive problems	____ growing pains
____ colic	____ bed wetting	____ headaches
____ migraines	____ seizures	____ allergies
____changes in mood	____ ADHD	____ scoliosis
____ back pain	____ croup/ cough	____ difficulty sleeping
____ anxiety	____ depression	

Are there any other symptoms or conditions your child is experiencing that are not listed above?
_____
_____

Family history of scoliosis? Yes or No
Are there any health conditions with anyone at home? Please describe:
_____

Were there any interventions or complications in the birth process? (ie: cesarean birth, forceps, vacuum extraction, inductions of labor, anesthesia, epidural etc)_____

_____

Has your child been developing normally? If no, please describe. _____

_____

Has your child ever been involved in any kind of accident? (At the playground, daycare, bicycle, sports auto accident etc.) _____

_____

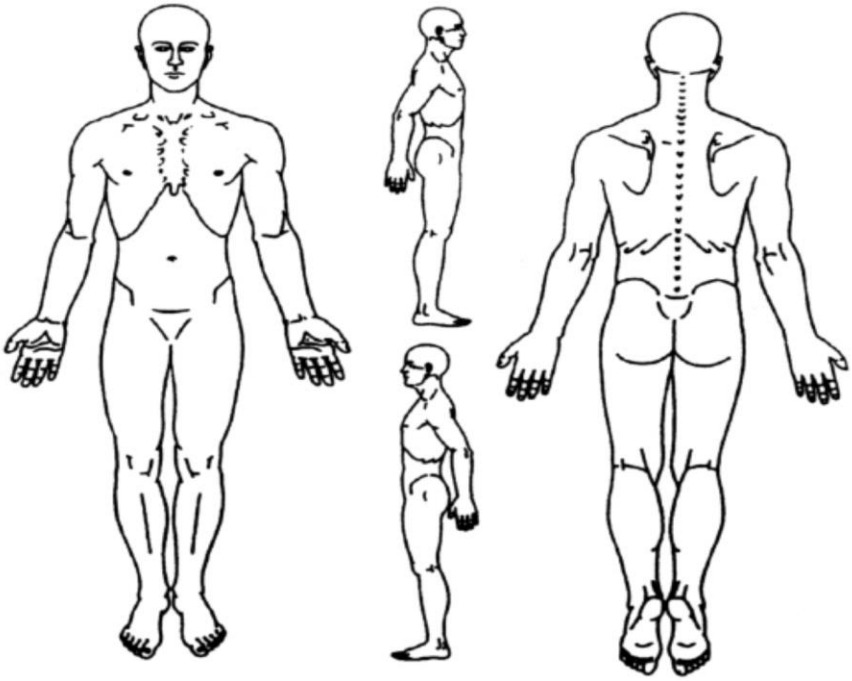
Has your child ever fallen from ANY height? Please describe: _____

_____

What symptoms does your child experience? Circle and/ or List ie: shooting, sharp, stiffness, aching, burning, nausea etc: _____

What activities or movements increase your child's symptoms? Circle and/ or List ie: bending, lifting, running, jumping, concentrating, etc._____

On the diagram below, please indicate where the child is experiencing pain right now. Please mark the exact locations using the following abbreviations:
P = Pain T = Tingling N = Numbness B = Burning S = Stiffness



Circle the severity of your pain on the scale 1-10 with 10 being extreme pain.

1 2 3 4 5 6 7 8 9 10

Signature on file
I authorize use of this form on **all** my insurance submissions. I authorize release of information to all my **Insurance Companies.** I understand that **I am responsible** for my bill. I authorize Dr. Chris Hawkins to act as **my** agent in helping me obtain payment from my Insurance Companies. I authorize payment direct to West Michigan Chiropractic Center, P.L.C. I permit a copy of this authorization to be used in place of the original.

Printed name: _____ **Signature:** _____