Edgewater Chiropractic Clinic, P.A.
201 S. Ridgewood Ave, Suite 11
Edgewater, FL 32132
386-423-7575

Patient Name: ______________________ **Date:** ______________

Address: ____

City______________________ **State**__________ **Zip Code**__________

Phone: ______________ ☐H☐ W☐ C 2nd Phone______________☐H ☐W ☐C

Gender: ☐ **M** ☐ **F** **DateofBirth:** __________**Age:**________**Marital Status:** ☐M☐D☐ S☐W

Race: Not Specified White Am. Indian or Alaska Native Asian Black/African Am. Hispanic

Occupation: ____

Email: ______________________**Preferred Language:** ______________

If you were referred by someone to our office please tell us who so we may thank them.

____

Have you seen a Chiropractor in the past?☐**Yes** ☐ **No**

If yes, who ______________________**Year?**__________

Emergency Contact: ______________________ **Phone:** ______________

Do you have health insurance? ☐**Y** ☐**N** **Please Present Card at Window**

Primary Care Physician: ______________**Where?** ______________

Last Physical Exam: ____

For sign-in purposes please select a 4-digit pin number ____ ____ ____ ____

Are you currently experiencing any of the following symptoms?

- ☐ Nausea or vomiting
- ☐ Numbness on one side of the face or body
- ☐ Fainting or lightheadedness
- ☐ Dizziness
- ☐ Difficulty walking
- ☐ Rapid eyemovement
- ☐ Difficulty speaking
- ☐ Headache or neck pain
- ☐ Difficulty swallowing
- ☐ Double vision

What current problem(s) bring you to the clinic today? ____________________

____

Date this condition began: ____________________

Has this pain ever happened before? ☐Y ☐N When:____________________

How Long Did It Last? ____________________

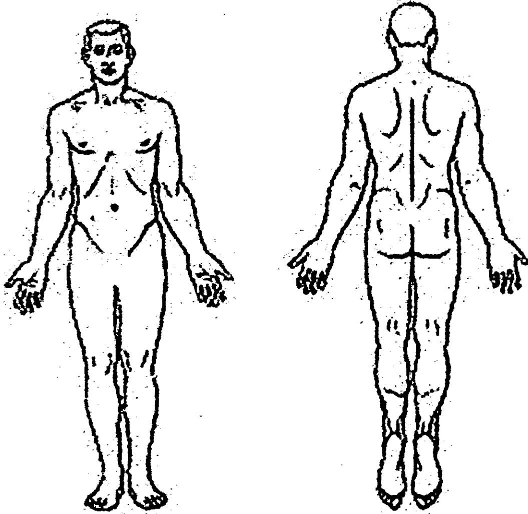
Are you currently being treated for this condition? ☐Yes ☐No

By Whom?____________________

Have you had any of the following tests? ☐X-rays ☐EMG ☐MRI ☐CT Scan

If yes, Year__________Where____________________ Why ____________________

Please circle area(s) where you are feeling symptoms...



How did this happen:

- ☐ FALL
- ☐ LONG DRIVE
- ☐ LONG
- ☐ POOR NIGHT'S SLEEP
- ☐ SLIP
- ☐ LIFTING
- ☐ REACHING
- ☐ HOUSEHOLD CHORES
- ☐ YARD WORK
- ☐ CHRONIC ILLNESS

Frequency of pain: (please check one)

- ☐ Constant (100% of the time)
- ☐ Frequent (< 75% but > 50% of the time)
- ☐ Occasional (< 50% but > 25% of the time)
- ☐ Intermittent (less than 25% of the time)

What type of pain are you experiencing? (please check all that apply)

- ☐ Aching
- ☐ Annoying
- ☐ Burning
- ☐ Deep
- ☐ Dull
- ☐ Heavy
- ☐ Intolerable
- ☐ Pulling
- ☐ Sharp"Shock Like"
- ☐ Stabbing
- ☐ Stiffness
- ☐ Throbbing
- ☐ "Tightness"
- ☐ Tingling

Is your pain Radiating? ☐Y ☐N Please Describe ____________________

____

Since the pain began has it: (please circle)

- ☐Improved
- ☐ Stayed the same
- ☐ Worsened
- ☐ Relief which lasted for a while

Pain level: ☐1 ☐2 ☐3 ☐4☐5 ☐6 ☐7 ☐8☐9☐10

Symptoms Relieved By: (checkone)

- ☐ None
- ☐ Chiropractic Adjustment
- ☐ Cold Pack
- ☐ Heat Packs
- ☐ Exercise
- ☐ Massage
- ☐ OTC Medication
- ☐ Physical Therapy
- ☐ Prescription Medication
- ☐ Rest
- ☐ Stretching
- ☐ Work

Activity of Daily Living Most Effected? (Check All That Apply)

- ☐ Employment
- ☐ Homemaking
- ☐ Lifting
- ☐ Personal Care
- ☐ Standing
- ☐ Walking
- ☐ Sitting
- ☐ Sit to Stand
- ☐ Sleeping
- ☐ Social Life
- ☐ Traveling
- ☐ Yard Work
- ☐ Sitting at Computer
- ☐ Caring for Family
- ☐ Golfing
- ☐ Exercise

What tasks do you find difficult due to the pain? (Check All That Apply)

- ☐ bending over
- ☐ caring for family
- ☐ climbing stairs
- ☐ concentrating
- ☐ dressing self
- ☐ driving car
- ☐ exercising
- ☐ getting in/out of car
- ☐ getting to sleep
- ☐ grocery shopping
- ☐ performing household chores
- ☐ lifting objects
- ☐ looking over shoulder
- ☐ making love
- ☐ lying down
- ☐ reaching overhead
- ☐ rising out of chair or bed
- ☐ showering or bathing
- ☐ sitting
- ☐ standing
- ☐ staying asleep
- ☐ using a computer
- ☐ walking
- ☐ participating in yard work

How long can you with stand activity before it begins to hurt?

☐1 ☐5 ☐10 ☐15 ☐20 ☐30 ☐45 ☐60

☐ Second ☐ Minute ☐ Hour

Is Your pain worse (please circle)? ☐Morning ☐Afternoon ☐Night

Are you currently under significant amount of stress? ☐ Yes ☐ No

Reason____

Please Circle...If YOU have ever been told you havehad or are currently experiencing any of the following:

- ☐Headaches
- ☐Dizzy
- ☐Light Headed
- ☐Loss of Balance
- ☐Fainting
- ☐Blurred Vision
- ☐Loss of Hearing
- ☐Ringing in Ears
- ☐Head Feels Heavy
- ☐Fatigue
- ☐Difficulty Swallowing
- ☐Nervous
- ☐Sores That Won't Heal
- ☐Thyroid Dysfunction
- ☐Weight Loss/Gain
- ☐ Abdominal Pain
- ☐ Any Bleeding/Discharge
- ☐ Wart/Mole Changes
- ☐ Cancer
- ☐ HIV
- ☐ Numbness
- ☐ Pins/Needles in Arms/Hands
- ☐ Loss of Grip/Strength
- ☐ Pain into Buttocks
- ☐ Persistent Cough
- ☐ Heart Murmur
- ☐ Chest Pain
- ☐ Shortness of Breath
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Osteomalacia
- ☐ Rheumatoid Arthritis
- ☐Stiff Neck
- ☐ Neck Pain
- ☐ Shoulder Pain
- ☐ Arm/Hand/ Pain
- ☐ Low Back Pain
- ☐ Pain Down Leg
- ☐ Mid Back Pain
- ☐ Ankle Pain
- ☐ Knee Pain
- ☐ Pain into Thigh
- ☐ Foot Pain
- ☐ Pain Between Shoulders
- ☐ Muscle Spasm in Neck
- ☐ Muscle Spasm in Shoulder
- ☐ Muscle Spasm in Mid Back
- ☐ Muscle Spasm in Low Back

Current medication, including frequency and dosage if known. If there are no current medications check here: ☐

1) ____________________ 5) ____________________

2) ____________________ 6) ____________________

3) ____________________ 7) ____________________

4) ____________________ 8) ____________________

List any known allergies you have had to any MEDICATIONS.
If no allergies are known, check here: ☐

1) ______________________ **3)** ______________________

2) ______________________ **4)** ______________________

Briefly list additional health conditions: ______________________

____

Has any doctor diagnosed you with Hypertension presently?☐ Yes ☐No

If yes, describe: ______________________

Has any doctor diagnosed you with Diabetes presently?☐ Yes ☐ No If yes, what kind?
☐ Type I ☐ Type II

If yes to Diabetes, was your blood lab-work test for hemoglobin A1c > 9.0%?
☐ Yes☐ No☐ Not Sure

If yes, other comments regarding Diabetes: ______________________

Have you had a knee replacement? ☐ **Yes** ☐**No** ☐**Right** ☐ **Left Year**______________

Have you had a hip replacement? ☐**Yes** ☐**No** ☐**Right**☐ **Left Year**______________

Do you have any family history in your mother, father, sibling or grandparents of BACK PAIN, HEADACHES, CANCER, DIABETES, STROKE, ARTHRITIS OR HEART DISEASE?☐ Y ☐N

If yes: Who?______________________

What conditions?______________________Age deceased__________

If yes:Who?______________________

What conditions?______________________Age deceased__________

If yes: Who?______________________

What conditions?______________________Age deceased__________

Any broken bone?☐Y ☐ N

Describe______________________Year?__________

Describe______________________Year?__________

Had any surgeries?☐Y☐N

Describe______________________Year?__________

Describe______________________Year?__________

Describe______________________Year?__________

Describe______________________Year?__________

Do you have a pacemaker?☐Yes ☐No
Are you or could you be pregnant?☐Yes ☐No
Due to Insurance guidelines, we must have 3 measurable goals when it comes to your treatment process. Please provide us with your goals.

1. ______________________

2. ______________________

3. ______________________

____
(Patient or Legal Guardian Signature) (Date)

Edgewater Chiropractic Clinic, PA.
201 S Ridgewood Ave, Suite #11
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Phone: (386)423-7575

Name: ______________________ Accident Date: __________ Phone: ______________
Address: ______________________ City: ______________ Zip: __________
Your Auto Insurance: ______________________ Claim # ______________
Agents Name: ______________________ Policy #______________
Other Driver Ins: ______________________ Agent Phone# ______________
Have you retained and attorney? ☐YES ☐ NO Attorney: ______________

NATURE OF ACCIDENT

1. What was the type of vehicle?______________________
2. What size/type of vehicle collided with your vehicle? (CIRCLE) bicycle, motorcycle, moped, scooter, small car, mid size car, SUV, Truck, Large Truck
3. Date of Accident: ______________________
4. Were you: ( )Driver ( )Passenger ( )Front Seat ( )Back Seat
5. Were you wearing a seatbelt? ( )yes ( )no
6. Did the airbag deploy? ( ) Yes ( ) No
7. Did your head hit headrest? ( ) Yes ( ) No
8. Where were you looking at the time of the impact:______________________
9. Did your body strike the inside of your vehicle? ( )yes ( )no If yes, describe______________________
10. Were you knocked unconscious? ( ) Yes ( ) No If Yes, for how long? ______________________
11. Point of impact? ( )head on ( )left front ( )right front ( )rear-end ( )left rear ( )right rear
12. What was your vehicle doing at the time of the accident? ( )stopped in traffic( )stopped at an intersection
13. ( )stopped at a light ( )making a right turn ( )making a left turn ( )parking ( )proceeding along ( )slowing down ( )accelerating ( ) other______________________
14. What was the estimated speed of the vehicle you were driving in: ______________________
15. What type of vehicle damage? ( ) Heavy ( ) Moderate ( ) Slight visible damage ( ) None ( ) Totaled
16. Other vehicle's movement? ( ) Backing up ( ) Stopped ( ) Moving forward ( ) Turning left ( ) Turning right
17. What was the estimated speed of other vehicle:______________________
18. How much damage is estimated to other vehicle: ( ) Heavy ( ) Moderate ( ) Slight visible damage ( ) None ( ) Totaled
19. Was your vehicle towed from the scene? ( ) Yes ( ) No
20. Were police notified? ( ) Yes ( )No
21. Was there an Accident report? ( ) Yes ( ) No
22. Was EMS called to the Scene? ( ) Yes ( ) No
23. Have you received any treatment since the accident? ( ) Yes ( ) No Type?______________________
24. Where were symptoms felt at the time of the accident? ______________________
25. Any Additional Symptoms at the time of the accident (supplemental)?______________________
26. Status of symptoms since accident? ( ) Worse ( ) Improved ( ) Disappeared ( ) Stayed the same
27. Did you go the emergency room and/ or doctor after the accident? ( ) yes ( )no
28. How did you get there?______________________
29. In your own words, please describe the accident: ______________________

30. Did you have any physical complaints BEFORE the accident? ( )YES ( )NO
31. If YES, please describe in detail: ____________________
____
32. Please describe how you felt:
33. DURING the accident: ____________________
34. IMMEDIATELY AFTER: ____________________
35. LATER THAT DAY: ____________________
36. What are your PRESENT complaints and symptoms? ____________________
37. Have you had any care since the accident?____________________
38. Were you treated at the hospital following the accident?
39. What treatment were you given at the hospital____________________
____

Edgewater Chiropractic Clinic, PA.

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Informed Consent for Chiropractic Treatment

TO THE PATIENT:

I hereby request and consent to the performance of chiropractic adjustments and any other chiropractic procedures, including examination tests, diagnostic x-ray(s) and physical therapy techniques, on me (or on the patient named below for which lam 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 back-up for the doctor of chiropractic named below. I understand that, as with any health care procedure, there are certain complications, 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 procedure(s) which the doctor feels at the time, based upon the facts then known, are in my best interest. 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. All of my questions have been answered to my satisfaction. Having been informed of the risks, I hereby give my 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(s) for which I seek treatment.

____
Patients Printed Name

____
Signature of Patient

____
Date

____
Patients Printed Name

____
Printed Name of Patient's Representative

____
Signature of Patient's Representative

____
Relationship/Authority of Patient's Representative

____
Date

Edgewater Chiropractic Clinic, PA.

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Health Care Authorization:

The patient below authorizes Edgewater Chiropractic Clinic PA and its employees to use and/or disclose protected health information in accordance with the following:

Specific Authorizations: I give permission to Edgewater Chiropractic Clinic PA, and its employees to use my phone number, email address, home address and clinical records to contact me with appointments, reminders, missed appointments notification, birthday cards, holiday related cards, information about treatment alternatives, or other health related information.

If Edgewater Chiropractic Clinic PA, and its employees contact me by phone, I give them permission to leave a phone message on my answering machine/voice mail.

By signing this form, I am giving Edgewater Chiropractic Clinic PA, and its employees my permission to use and disclose my protected health information in accordance with the directives above.

Right to revoke authorization:

I have the right to revoke the above authorization by mailing or hand delivering a written notice to the privacy official of Edgewater Chiropractic Clinic PA. The written notice must contain the following information: My name, social security number, date of birth, a clear statement of my intent to revoke this authorization, the date and my signature. The revocation will not be effective until it is received by the privacy official. I have the right to refuse this authorization. If I refuse to sign it, Edgewater Chiropractic Clinic PA, will not refuse to provide treatment.

I have the right to inspect or copy the health information to be used/disclosed. I have a right to a copy of the signed authorization.

Patient's PRINTED Name: ____

Patient's Signature: ____ Date: ____________

Edgewater Chiropractic Clinic, PA.

S. Ridgewood Ave, Suite 11
Edgewater, FL. 32132
Phone: (386)423-7575

EDGEWATER CHIROPRACTIC CLINIC:

NOTICE REGARDING YOUR RIGHT TO PRIVACY

I have received a copy of the Patient Privacy Notice. I understand my rights as well as the practice's duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this "Notice of Privacy Practice" at a time in the future and will make the new provisions effective for all information that it maintains past and present. I am aware that a more comprehensive version of this "Notice" is available to me and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

____

Printed Name

____

DOB

____

Signature

____

Date

Edgewater Chiropractic Clinic, PA.

201 S. Ridgewood Ave, Suite 11
Edgewater, FL. 32132
Phone: (386)423-7575

This office is required to notify you in writing, thatby law, we must maintain the privacy and confidentiality of your PersonalHealthInformation. In addition, we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which,by law, or as dictated by our office policy,we are permitted todisclose information about you to a third party without your authorization. Below is a brief summary of these circumstances.If you would like a more detailed explanation, one will be provided to you. In addition, you will find we have placed several copies in report folders labeled 'HIPAA'on tables in the reception. Once you have read this notice, please sign the last page, and return only the signature page (page 2) to our front desk receptionist. Keep this page for your records.

PERMITTED DISCLOSURES:

1.Treatment purposes discussion with other health care providers involved in your care.
2.Inadvertent disclosures open treating area mean open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3.For payment purposes to obtain payment from your insurance company or any other collateral source.
4.For workers compensation purposes to process a claim or aid in investigation.
5.Emergencyin the event of a medical emergency we may notify a family member.
6.For public health and safetyin order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7.To Government agencies or Law enforcement to identify or locate a suspect, fugitive, material witness or missing person.
8.For military, national security, prisoner and government benefitpurposes.
9.Deceased personsdiscussion with coroners and medical examiners in the event of a patient's death.
10.Telephone calls or emails and appointment reminders we may call your home and leave messagesregarding a missed appointment or apprize you of changes in practice hours or upcoming events.
11.Change of ownershipin the event this practice is sold, the new owners would have access to your PHI.

YOUR RIGHTS:

1. To receive an accounting of disclosures.
2.To receive a paper copy of the comprehensive "Detail" Privacy Notice.
3.To request mailings to an address different than residence.
4.To request restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove therestriction.
5.To inspectyour records and receive one copy of your records at no charge, with notice in advance.
6.To request amendments to information. However, like restrictions, we are not required to agree to them.
7.To obtain one copyof your records at no charge, when timely notice is provided (72 hours). X-raysare original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center, to have copiesmade, we will be happy to accommodate you. However, you will be responsible for this cost.

COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information, please call
Dr. Carly Meckle (386) 423-7575.Ifshe is unavailable, you may make an appointment with our receptionist to see her within72 hours or 3 working days. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to: DHHS, Office of Civil Rights

200 Independence Ave. SW
Room 509F HHH Building
Washington DC 20201

Edgewater Chiropractic Clinic, PA.

201 S Ridgewood Ave, Suite #11
Edgewater, FL. 32132
Phone: (386)423-7575

ASSIGNMENT OF BENEFITS

I hereby authorize and direct you, my insurance company and/or my attorney, to pay directly to Carly Meckle, D.C. or Edgewater Chiropractic Clinic, PA, ("Assignee") such sums as may be due and owing Assignee for the services rendered to me, both by reason of accident or illness, and by reason of other bills that are due to the Assignee, and to withhold such sums from any disability benefits, medical payment benefits, No-Fault benefits, or any other necessary to adequately protect said Assignee. In the event that I do not have insurance coverage, I understand that I remain personally responsible for payment of services rendered. I hereby further give an irrevocable lien to said Assignee against any and all insurance benefits named herein and any and all proceeds of any settlement, judgment or verdict which may be paid to me as a result of the injuries or illness for which I have been treated by the Assignee. This is to act as an assignment of my rights and benefits to the extent of the Assignee's services provided.

ASSIGNMENT OF CAUSE OF ACTION

In the event my insurance company is obligated to make payments to me upon charges made by the Assignee for tits services refuses to make such payment, upon demand by me or Assignee, I hereby assign and transfer to Assignee any and all causes of action, and proceeds from such causes of action, that I might have or that might exist in my favor against such company and authorize Assignee to prosecute said cause of action either in my name or Assignee's name and further I authorize Assignee to compromise settle or otherwise resolve said claim of action as they see fit.

DIRECTION OF PAYMENT

I hereby authorize any insurance company or attorney to pay directly to Assignee the amount of this and/or any future bills for services rendered to me. I also agree to pay in a current manner any difference between the total charges and the amount paid by the insurance company directly to Assignee.

PIP LOG REQUEST

I hereby authorize Assignee to release an information requested that is pertinent to my case to my insurance company or attorney involved in this case. Pursuant 627.4137 Florida Statutes (2001), I hereby request a copy of the pip log and declaration sheet, which reflects the policy limits available at the time of this accident, to be provided to Assignee. I hereby authorize Assignee to request and receive a copy of my pip log periodically as the y deem to be necessary.

RESERVATION OF BENEFITS

Please be advised that I am hereby placing you on notice that pursuant to Florida case law, should you deny, reduce or fail to pay either a portion of or an entire bill submitted on my behalf from this healthcare provider. I am requesting that you reserve, or hold aside, that same amount until this dispute is resolved.

Any term or provision of this Assignment, Lien and Authorization or the application thereof to any person or circumstances shall to any extent be invalid or unenforceable to the remainder of this Assignment, Lien and Authorization, or the application of such term or provision o persons or circumstances other than those as to which it is held invalid or unenforceable, shall not be affected thereby, and each term and provision of this Assignment, Lien, and Authorization shall be valid and enforced to the fullest extent of the law.

Patient Signature: ______________________________ **Date:** ____________________

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 said doctor above named.

Signature: ____ **Date:** ____________

LETTER OF PROTECTION EDGEWATER CHIROPRACTIC CLINIC P.A.

Name________________________________
Birth Date____________________________
Date of Accident______________________
Address______________________________
____
____

Insured's name__________________________
Policy #______________________________
Claim #_______________________________
Adjustor_____________________________
Address______________________________

Protection of Outstanding Charges. If the above named client recovers money damages from any person or entity responsible for charges incurred by the above named health provider, we agree to withhold from any check or draft in which we are an additional named payee, sufficient funds, after deduction of attorney's fees and costs, to pay any outstanding medical bills in our possession for any and all undisputed charges owed to you in connection with the accident or event giving rise to and covered by the recovery and not covered by any collateral source.

Amount Protected. It is the health provider's obligation to furnish us with periodic updates of outstanding charges. Otherwise, we will rely on previously received records in seeking reimbursement from the tortfeasor. Under no circumstances will we withhold a sum larger than that submitted to the tortfeasor for reimbursement.

I fully understand that I am directly and fully responsible to **Edgewater Chiropractic Clinic** to pay all bills submitted for services rendered to me, and that this agreement is made solely for said company's additional protection and in consideration of his awaiting payment. I further understand that such payment is not contingent on any settlement, claim, judgment, or verdict by which I may eventually recover said fee.

I fully understand that, should I terminate the services of the above-named attorney, I must notify **Edgewater Chiropractic Clinic** immediately and provide an additional letter of protection from another attorney, submit payment in full, or make payment arrangements with our office for services already rendered.

Please be advised, we will do our best to protect your outstanding bills however, this Letter of Protection cannot be used to protect your office from any balance due as a result of improper billing by your office. Please make sure your billing department fully complies with all applicable billing rules, regulations and statutes, including Florida Statute Section 627.726. We can only protect your fees to the extent provided for under the applicable Fee Schedule in effect under Section 627.736, Florida Statutes.

Pro Rata Distribution If Inadequate Recovery. If the net recovery is less than the total outstanding charges owed to all health providers covered by a letter of protection or any other lien holder, such funds will be distributed on a pro rata basis.

Our Responsibility on Forensic Services. This law firm acknowledges independent responsibility to the health provider for charges incurred for medical records and witness fees.

Disputes. If our client disputes any of your outstanding charges or claims a setoff and we are unable to resolve the issue, we will deposit the amount of the disputed charge/set off into the court registry for judicial determination.

____
Patient/Guardian Signature PRINT Patient/GuardianNameDate

The undersigned, being attorney of record for the above patient does hereby acknowledge receipt of the above lien, and does agree to honor the same to protect adequately said above-named company

________________________________ ______________________________
Attorney's Signature PRINT Attorney's Name

____
Date