612 S. Jones Blvd.
Las Vegas, NV 89107
702-501-3700
702-876-1175 (fax)
info@oasismedicalmassage.net

Oasis Medical Massage

MEDICAL LIEN
SUBROGATION CONTRACT

Date:_____Patient SS#(last 4):_____Patient's DOB_____Patient's Acct#_____

To: Attorney's Name_____

Address_____

_____

Phone#_____

Fax#_____

e-mail_____

Payment to Provider: I, _____ ("Patient"), hereby authorize and direct you _____ ("Attorney"), my attorney to pay directly to **Oasis Medical Massage** ("Provider") such amounts as may be due and owing to Provider for services which includes, but is not limited to, all services rendered by medical personnel, facility charges, and any supplies associated with my medical care, regardless of whether such supplies are provided by the facility, the physician and/or any third-party vendor (the "Treatment") I received as a result of the personal injuries I suffered on _____ (the "Incident").

Withholding of Funds for Benefit of Provider: Patient further instructs Attorney to withhold such sums from any settlement, judgment, court ruling, or verdict relating to the Incident to compensate Provider and shall tender payment in full to Provider before disbursing any payment to Patient. Patient is Responsible to Provider for Payment: Patient fully understands that Patient remains directly and fully responsible to Provider for all bills submitted by it for Treatment and that the purpose of this Medical Lien and Subrogation Contract (the "Subrogation Contract") is solely for Provider's protection and consideration while awaiting payment. Patient

further understands that the amount Patient owes Provider is not contingent upon any settlement, judgment, court rulings, verdict or recovery which Patient may eventually receive.

Retention of New Attorney: If Attorney refuses to honor this agreement, Provider will not await payment and Patient will be required to immediately pay Provider in full. Patient acknowledges that he or she is responsible for notifying Provider in the event Patient retains a new lawyer to represent Patient in connection with the Incident. If Patient retains a new lawyer, the new lawyer shall notify Provider in writing within forty-eight (48) hours of the retention that the new lawyer agrees to be bound by the terms of this Subrogation Contract. If Provider is not provided such notification or if Patient's new lawyer will not agree to the terms of this Subrogation Contract, Patient shall be responsible for immediate payment in full of all amounts due and owing to Provider.

Assignment by Provider to Assignee: Patient and Attorney acknowledge that Provider reserves the right, in its sole and absolute discretion, to assign its rights under this Subrogation Contract and the underlying Accounts Receivable to a third-party (the "Assignee") for any consideration that Provider deems sufficient. Patient and Attorney further acknowledge that they will be bound by this Subrogation Contract to the Assignee as if Assignee is the Provider. Further, Patient agrees to remain liable to Provider's Assignee for the full billed charges of any Treatment rendered by Provider to the Patient. Patient and Attorney understand and acknowledge that the charges will not be known until the conclusion of the treatment rendered to Patient by Provider. The amount Assignee pays Provider for Patient's Treatment will not necessarily be the total amount of the billed charges. The negotiated payment between an Assignee and Provider shall not change Patient's financial obligations to Assignee under the terms of this Subrogation Contract, which are the billed charges for the Treatment.

Patient Initials: _____

Authorization for Release of Medical Records: Patient authorizes Attorney to disclose information regarding the status of Patient's case to Provider or Assignee, if an assignment has been made, and agrees to execute an authorization/release to accomplish this disclosure. In the event of an assignment by the Provider, Patient hereby authorizes Provider to release any and all of Patient's medical records to the Assignee. Patient acknowledges and consents that the released information may contain alcohol, drug abuse, psychiatric, STDs, Genetic testing, AIDS information, or other abuse related information. This authorization for release of medical records will expire upon payment in full to Provider or Assignee. Patient may revoke the authorization for release of medical records at any time upon request. However, in the event Patient revokes the authorization, Patient shall be responsible for immediate payment in full of all amounts due and owing to Provider or Assignee. Further, the revocation of this authorization will not have any affect on any actions taken prior to receiving the revocation. Patient acknowledges that he or she may refuse to sign this authorization and that it is strictly voluntary. Patient further directs Attorney to do everything necessary to ensure compliance with the Health Insurance Portability and Accountability Act (HIPAA).

Patient Initials: _____

Granting of Lien Rights: Patient hereby grants Provider a lien, pursuant to NRS 108.590 through 108.660, inclusive, upon any sums awarded to Patient or his/her personal representative, by judgment or pursuant to a settlement or compromise in the amount and to the extent of Provider's billed charges. This lien includes, but is not limited to, the charges for services rendered by medical personnel, facility charges, and any supplies (including implants) associated with the medical care of Patient, regardless of whether such supplies are provided by the facility, the physician and/or any third-party vendor which, in some cases, may be invoiced to the Assignee separately. Patient authorizes Provider or Assignee to disclose whatever information is necessary in order to protect and/or perfect the lien rights granted hereunder.

Provider Assumes Full Responsibility for Treatment: Patient expressly acknowledges that no Assignee (actual or potential) has directed, counseled or otherwise given advice to Patient or Provider as to the medical services, treatment and/or supplies to be provided to Patient. All decisions regarding the care and treatment of Patient have been and are being made solely by Patient and Provider. Patient further acknowledges and agrees that Assignee neither assumes nor bears any liability for any professional negligence by any health care provider participating in the medical services and related medical treatments nor has any Assignee counseled or given advice to Patient with respect to any medical services to be provided.

Patient Initials:_____

Representation Concerning Medical Insurance: It is expressly understood by Patient that a potential or actual Assignee relies upon Patient's representation that no health insurance coverage exists when determining whether to obtain an assignment from the Provider.

Patient Initials:_____

Patient hereby understands that if health insurance information is not presented at the time of service and the Patient's account/accounts receivable is assigned at some time in the future to an assignee who pays consideration to acquire the account/accounts receivable inquire and assume financial cost and risks; Patient will not later claim that health insurance should have covered the service provided, nor shall Patient seek a discount from the assignee so as to pay an amount that an insurance payor would have purportedly paid if health insurance information had been initially furnished to Provider and Assignee shall have the right to collect from Patient the full amount of the billed charges.

Patient Initials:_____

Patient further affirmatively represents that no person has stated, recommended, counseled,

advised or otherwise suggested that Patient should not utilize any health insurance for treatment to be rendered to Patient.

Patient Initials:_____

Direct Payment to Provider or Assignee: Patient acknowledges that Assignee has the right to endorse and deposit checks made payable to Provider or Patient for Treatment rendered by Provider to Patient on dates of service for which Assignee has purchased from Provider the right to payment for those services. Patient further authorizes Provider and Assignee to bill directly any applicable insurance company for any medical payment or other benefits to which Patient may be entitled under Patient's motor vehicle insurance.

Waiver of Time Bar Defenses: Patient expressly waives any applicable time limitation defense, including any statute of limitations, statute of repose, or the equitable defense of laches regarding Provider or Assignee's right to recover payment for the Treatment rendered by Provider to Patient.

Entire Agreement. This Subrogation Contract constitutes the final, complete and exclusive statement of the terms of the agreement between the parties. No party has been induced to enter into this Subrogation Contract by, nor is any party relying on, any representation or warranty outside those expressly set forth in this Subrogation Contract. Further, this Subrogation Contract may not be changed orally, but only by a written instrument executed by all parties to this Subrogation Contract.

Construction. The terms and conditions of this Subrogation Contract shall be construed as a whole according to its fair meaning and not strictly for or against any party. Patient, Attorney, and Provider acknowledge that each of them has reviewed this Agreement and has had the opportunity to have it reviewed by their attorneys and that any rule or construction to the effect that ambiguities are to be resolved against the drafting party shall not apply in the interpretation of this Subrogation Contract, including any amendments.

Attorney's Fees. In any proceeding to enforce the terms of this Subrogation Contract or to redress any violation of this Subrogation Contract, the prevailing party shall be entitled to recover as damages its attorney's fees and costs incurred, whether or not the action is reduced to a final award or to judgment. For the purposes of this provision, the "prevailing party" shall be that party who has been successful with regard to the main issue, even if that party did not prevail on all the issues.

Binding Effect. This Agreement shall inure to the benefit of and be binding upon Patient, Attorney, Provider and their respective heirs, successors, and assigns. Except as specifically provided herein, this Subrogation Contract is not intended to create, and shall not create, any rights in any person who is not a party to this Subrogation Contract.

Governing Law and Forum. The laws of the State of Nevada applicable to contracts made or to be wholly performed there (without giving effect to choice of law or conflict of law principles) shall govern the validity, construction, performance and effect of this Agreement.
Partial Invalidity. If any term of this Subrogation Contract or the application of any term of this Subrogation Contract should be held to be invalid, void or unenforceable, all provisions, covenants and conditions of this Agreement, and all of its applications, not held invalid, void or unenforceable, shall continue in full force and effect and shall not be affected, impaired or invalidated in any way.

Necessary Action. Patient, Attorney, and Provider shall do any act or thing and execute any or all documents or instruments necessary or proper to effectuate the provisions and intent of this Subrogation Contract.

Arbitration. In the event of any controversy or claim arising from the terms of this Agreement, the parties agree to resolve the dispute through binding confidential arbitration in Clark County, Nevada, or such other venue as agreed by the parties. The arbitration shall be initiated by the service of an arbitration demand by the claimant upon the other party to this agreement. After the arbitration demand is served, the parties shall mutually select an arbitrator, who is a licensed attorney whose practice is primarily located in Las Vegas, Nevada. In the event the parties are unable to select a mutually agreeable arbitrator within thirty (30) days of the initiation of the arbitration, Provider (or its assignee) shall have the right to select an arbitrator [or some other procedure]. The costs of the arbitration will be borne by both parties equally until the conclusion of the arbitration, at which time the arbitrator may grant a cost award in favor of the prevailing party. Should any party not timely pay their share of the arbitration fees after a 5 day notice of failure to pay and opportunity to cure, the non-paying party consents to the entry of an award and subsequent judgment in favor of party who has timely paid their share of the arbitration fees. The arbitration shall otherwise be conducted pursuant to the Commercial Rules of the American Arbitration Association.

PATIENT REPRESENTS TO PROVIDER AND ASSIGNEE THAT PATIENT HAS BEEN GIVEN THE OPPORTUNITY TO HAVE HIS OR HER LEGAL COUNSEL REVIEW THIS SUBROGATION CONTRACT AND HAS EITHER DONE SO OR HEREBY WAIVES THE RIGHT TO DO SO AND EXECUTES THIS SUBROGATION CONTRACT WITH FULL KNOWLEDGE AND UNDERSTANDING OF ITS TERMS AND CONDITIONS, AND AGREES TO BE BOUND BY ITS TERMS AND CONDITIONS.

Patient's signature_____ Date_____

Patient's name (please print)_____

Patient's address_____

Patient's telephone number_____

The undersigned, being attorney of record for the above Patient, does hereby agree to withhold from any settlement, judgment, court ruling, or verdict issued, rendered, or agreed to relating to the Incident sufficient funds to compensate Provider or Assignee and shall tender payment in full to Provider or Assignee before disbursing any payment to Patient. Attorney agrees that if there is a dispute between parties, such dispute shall be governed by Nevada law. Attorney acknowledges that Assignee has not counseled nor given advice to Attorney with respect to the provision of any legal services. If Attorney is discharged from representation of Patient, withdraws from the representation of Patient, or closes Patient's file without receiving any payments, then Attorney agrees to notify Provider or Assignee within forty-eight (48) hours of such discharge, withdrawal, or closing.

Attorney's signature_____ Date_____

A fax or photocopy of this document shall be considered as valid as the original

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Lien Client Intake Form

Today's Date:_____ Date of Incident:_____ Referred By:_____

Name:_____
Email:_____Cell:_____
Address:_____ Home:_____
City/State/Zip:_____ Date of Birth:_____
Driver's License Number: _____ State Issued:_____
Occupation:_____ Last 4 of SS#:_____
Employer:_____
Employer Address:_____
City/State/Zip:_____

Attorney Information:
Name:_____
Email:_____Phone:_____
Address:_____ Fax:_____
City/State/Zip:_____

Emergency Contact:_____ Relationship:_____
Emergency Contact Cell/Home Phone:_____

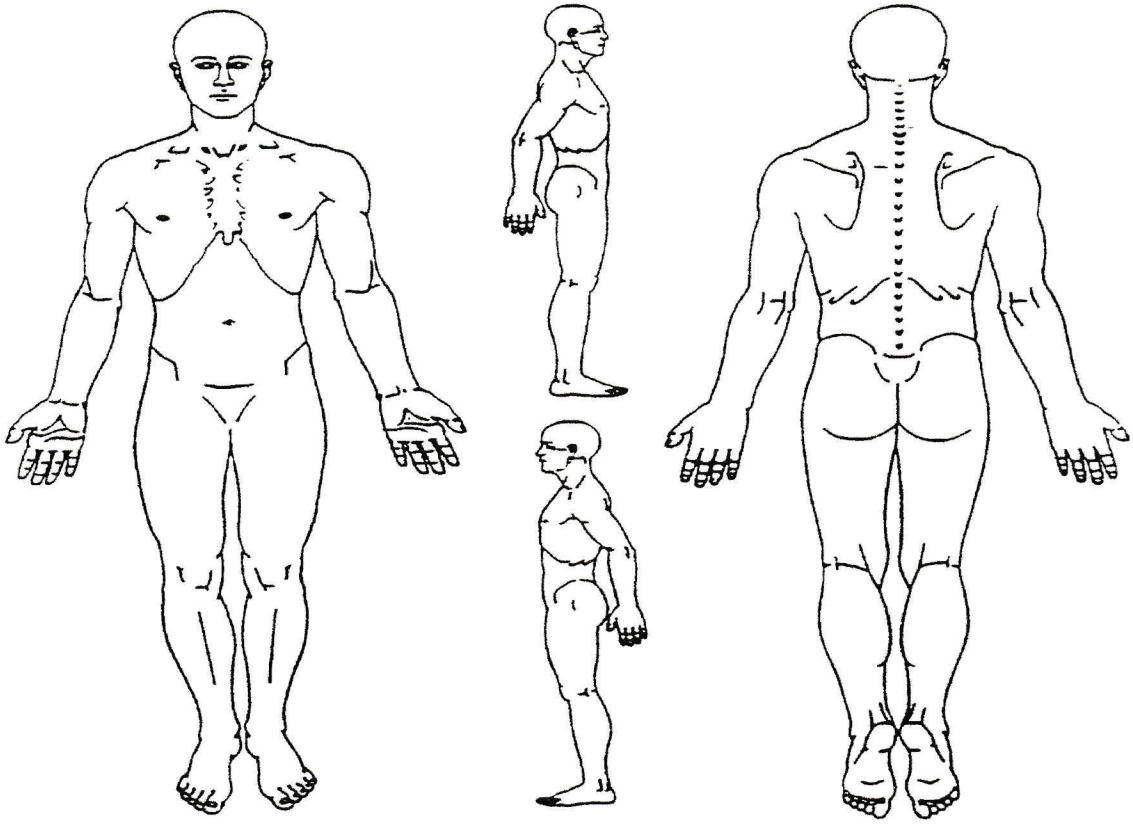
Briefly describe what happened:_____

Please use back of this page if needed

Oasis Medical Massage

Pain Diagram

Using the diagram below, please identify ALL areas that have pain, numbness and/or tingling; also please indicate intensity by circling appropriate level to areas that apply:



Head:	**1 2 3 4 5 6 7 8 9 10**
Neck:	**1 2 3 4 5 6 7 8 9 10**
Shoulder:	**1 2 3 4 5 6 7 8 9 10**
Mid Back:	**1 2 3 4 5 6 7 8 9 10**
Low Back:	**1 2 3 4 5 6 7 8 9 10**
Hip:	**1 2 3 4 5 6 7 8 9 10**
Tailbone:	**1 2 3 4 5 6 7 8 9 10**

Upper arm:	**1 2 3 4 5 6 7 8 9 10**
Elbow:	**1 2 3 4 5 6 7 8 9 10**
Forearm:	**1 2 3 4 5 6 7 8 9 10**
Wrist:	**1 2 3 4 5 6 7 8 9 10**
Hand:	**1 2 3 4 5 6 7 8 9 10**
Thigh:	**1 2 3 4 5 6 7 8 9 10**
Knee:	**1 2 3 4 5 6 7 8 9 10**
Lower Leg:	**1 2 3 4 5 6 7 8 9 10**
Ankle:	**1 2 3 4 5 6 7 8 9 10**
Foot:	**1 2 3 4 5 6 7 8 9 10**
Toes:	**1 2 3 4 5 6 7 8 9 10**

Health History

Circle the following conditions that apply to you, past AND present. Please add your comments to clarify the condition.

Musculo-Skeletal:
Headaches
Joint Swelling
Spasms/Cramps
Broken/Fractured Bones
Strains/Sprains
Back / Hip Pain
Shoulder / Neck / Arm / Hand Pain
Leg / Foot Pain
Chest / Ribs/ Abdominal Pain
Problems walking
Jaw Pain / TMJ
Tendinitis
Bursitis
Arthritis
Scoliosis
Bone or Joint Disease
Other:_____

Circulatory and Respiratory:
Dizziness
Shortness of Breath
Fainting
Cold Feet or Hands
Cold Sweats
Swollen Ankles
Pressure Sores
Varicose Veins
Blood Clots
Stroke
Heart Condition
Allergies
Sinus Problems
Asthma
High Blood Pressure
Low Blood Pressure
Lymphedema
Other:_____

Skin:
Rashes
Allergies
Athlete's Foot
Warts
Moles
Acne
Cosmetic Surgery
Other:_____

Digestive:
Nervous Stomach
Indigestion
Constipation
Intestinal Gas / Bloating
Diverticulitis
Irritable Bowel Syndrome
Crohn's Disease
Colitis
Adaptive Aids
Other:_____

Nervous System:
Numbness / Tingling
Twitching of Face
Fatigue
Chronic Pain
Sleep Disorders
Ulcers
Paralysis
Herpes / Shingles
Cerebral Palsy
Epilepsy
Chronic Fatigue Syndrome
Multiple Sclerosis
Muscular Dystrophy
Parkinson's Disease
Spinal Cord Injury

Reproductive:
Pregnancy:
Current / Previous
PMS
Menopause
Pelvic Inflammatory Disease
Endometriosis
Hysterectomy
Fertility Concerns
Prostate Problems

Other:
Loss of Appetite
Forgetfulness
Confusion
Depression
Drug Use:_____
Alcohol Use:_____
Nicotine Use:_____
Caffeine Use:_____
Hearing Impaired
Visually Impaired
Burning upon Urination
Bladder Infection
Eating Disorder
Diabetes
Fibromyalgia
Post Polio Syndrome
Cancer:_____
Infectious Disease:_____
_____
Other Congenital or
Acquired Disabilities:_____
_____
Surgeries:_____
_____
Other:_____

For clients requiring mobility assistance, please give your Height:_____ Weight:_____

Please list any additional comments regarding your health and well-being:_____
_____

I have stated ALL conditions true and accurate to the best of my knowledge. I will inform the health care provider of any changes in my status.

Client's Signature:_____ Date:_____

Massage Therapy Informed Consent

I, _____(Client) understand that massage therapy provided by Brigitte Papp, LMT, BCTMB, (Massage Therapist) is intended to enhance relaxation, reduce pain caused by muscle tension, increase range of motion, improve circulation, and offer a positive experience of touch. Any other intended purposes for massage therapy are specified below:

_____

_____

_____

The general benefits of massage, possible massage contraindications, and the treatment procedure have been explained to me. I understand that Massage Therapy is not a substitute for medical treatment or medications, and that it is recommended that I concurrently work with my Primary Caregiver for any condition I may have. I am aware that the Massage Therapist does NOT diagnose illness or disease, does NOT prescribe medications, and that spinal manipulations are NOT part of Massage Therapy.

I have informed the Massage Therapist of all my known physical conditions, medical conditions, medications , and I will keep the Massage Therapist updated on any changes. I understand that there shall be no liability on the practitioner's part due to my forgetting to relay any pertinent information.

If I experience any pain or discomfort during the session, I immediately communicate that to the therapist so the treatment can be adjusted.

I have received a copy of the therapist's policies, I understand them and agree to abide by them.

Client Signature: _____ Date:_____