PERSONAL INJURY QUESTIONNAIRE

Name: _____

Your Ins. Co.: _____ Policy #: _____ Agents Name: _____

Name on policy (if other than self): _____

Claim number: _____

Were there any witnesses? ( ) Yes ( ) No Name(s):_____

NATURE OF 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

on (name of street) _____

5. What direction was other vehicle headed? ( ) North ( ) East ( ) South ( ) West

on (name of street) _____

6. Were you struck from: ( ) Behind ( ) Front ( ) Left Side ( ) Right Side

Your vehicle make/model _____ Other vehicle make/model_____

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 complaint BEFORE THE ACCIDENT? ( ) Yes ( ) No

12. Please describe how you felt: _____

a. DURING the accident: _____

b. IMMEDIATELY AFTER the accident: _____

c. LATER that day: _____

d. THE NEXT day: _____

13. What are your present complaints and symptoms?

_____

_____

14. Do you have any congenital (from birth) factors which relate to this problem? ( ) Yes ( ) No If yes, please describe:

_____

15. Do you have any previous illnesses which relate to this case? ( ) Yes ( ) No If yes, please describe:

_____

16. Where were you taken after the accident? _____

Have you been treated by another doctor since the accident? ( ) Yes ( ) No If yes, please list doctor's name and address: _____

17. What type of treatment did you receive? _____

18. Since this injury occurred, are your symptoms: ( ) Improving ( ) Getting worse ( ) Same

19. Have you ever been involved in an accident before? ( ) Yes ( ) No If yes, please describe, including date(s) and type(s) of accidents, as well as any injuries received:

_____

_____

20. CHECK SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT:

__ Headaches	__Irritability	__Numbness in Toes	__Face Flushed
__Neck stiff	__Chest Pain	__Shortness of Breath	__Buzzing in Ears
__ Sleeping Problems	__Dizziness	__Fatigue	__Loss of Balance
__Back Pain	__Head seems too heavy	__Depression	__Fainting
__Nervousness	__Pins & Needles in Arms	__Lights Bother Eyes	__Loss of Smell
__Tension	__Pins & Needles in Legs	__Loss of Memory	__Loss of Taste
__Numbness in fingers	__Ears Ringing	__Diarrhea	__Fever
__Feet Cold	__Hands Cold	__Stomach Upset	__Constipation
__Cold Sweats			

__Other: _____

21.Have you lost time from work as a result of this accident? ( ) Yes ( ) No If yes, please complete these questions:

a. Last day worked: _____

b. Type of Employment: _____

c. Are you being compensated for the time lost from work: ( ) Yes ( ) No If yes, please state type of compensation you are receiving: _____

22. Do you notice any activity restrictions as a result of this injury? ( ) Yes ( ) No If yes, please describe in detail:

_____

_____

_____

23. Other pertinent information:

_____

_____

_____

Date: _____ Patient Signature: _____

REGISTRATION

Date: _____ Phone: _____

Patient: _____
Last Name First Name Initial

Street Address: _____

City/State/Zip Code: _____

Sex: ☐ M ☐ F Age: ____ Birth-date: _____ Height: ____ Weight: ____

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Social Security #: _____ Email: _____

Insured's Name: _____
Last Name First Name Initial

Primary care doctor: _____Phone: _____
Last Name First Name

Patient Agreement:
ASSIGNMENT AND RELEASE
I, the undersigned, have insurance coverage with _____
Name of Insurance Company
and assign directly to Dr. _____ all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

_____ _____
Signature of Insured/Guardian Date

Present Complaints (Please circle the appropriate ones)

Headache	Neck pain	Lower back pain
Mid-back pain	Upper back pain	Fainting
Loss of memory	Confusion	blurred vision
Dizzy	Nervousness	Irritability
Ears ringing/buzzing	Chest pain	Double vision
Shortness of breath	Loss of smell	Depression
Pins and needles in hands right/left	Pins and needles in arms right/left	Pins and needles in legs right/left

Medical Implants: _____ **Medical alerts: _____**
Surgical Implants: _____ **Pregnancy: YES__ NO ___**

Medications: *(please list all medications and supplements that you currently take)*

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

Allergies: *(please list all medications that cause allergic reaction)*

_____ _____ _____
_____ _____ _____
_____ _____ _____

Smoking: ___ Yes ___ No If yes, _____ Packs per Day for _____ years

Alcohol ___ Yes ___ No If yes, Number of drinks per week _____

Surgical History: Please list ALL previous surgeries and the date on which it was performed:
Surgery _____ Date _____

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Personal Medical History & Review of Systems:

Please indicate with an "X" any medical problems that you currently have or have had in the past.

□ **NO MEDICAL PROBLEMS** - no prior history of any significant medical problems

Please indicate with an "X" any significant family medical history or problems.

□ asthma □ tuberculosis □ sleep apnea
□ COPD or Emphysema □ other lung: _____
□ heart attack, myocardial infarction □ congestive heart failure
□ irregular heartbeat, arrhythmia □ bleeding problems
□ other heart: _____
□ Peripheral neuropathy □ MS or Parkinson's □ other neuro: _____
□ osteoarthritis □ Lupus □ gout
□ rheumatoid arthritis □ Other bone & joint: _____
□ acid reflux, GERD □ inflammatory bowel disease
□ hepatitis - Type _____
□ liver disease □ other GI: _____
□ kidney problems □ dialysis, kidney failure
□ diabetes □ psoriasis □ high cholesterol or lipids
□ thyroid problems □ sickle cell disease □ any skin ulcer
□ Malignant hyperthermia
Cancer: any type -- please specify _____

Other medical problems NOT included above (explain) _____
_____
_____

Family History:

Please indicate with an "X" any significant family medical history or problems.

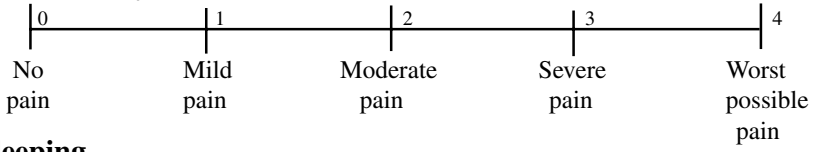
□ asthma □ tuberculosis □ sleep apnea
□ COPD or Emphysema □ other lung: _____
□ heart attack, myocardial infarction □ congestive heart failure
□ irregular heartbeat, arrhythmia □ bleeding problems
□ other heart: _____

Functional Rating Index

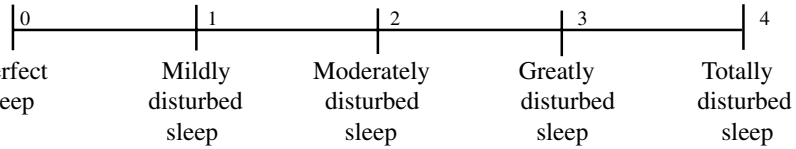
For use with **Neck and/or Back Problems** only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities.
For each item below, **please circle the number which most closely describes your condition right now.**

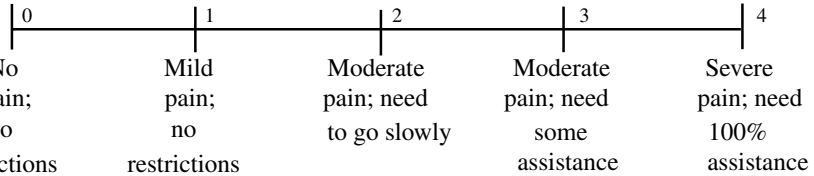
1. Pain Intensity



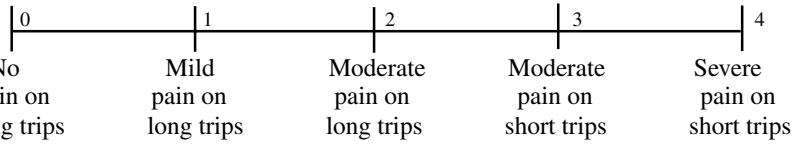
2. Sleeping



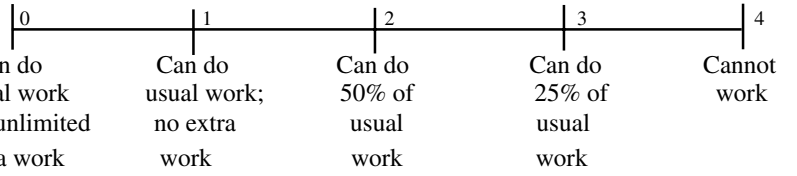
3. Personal Care (washing, dressing, etc.)



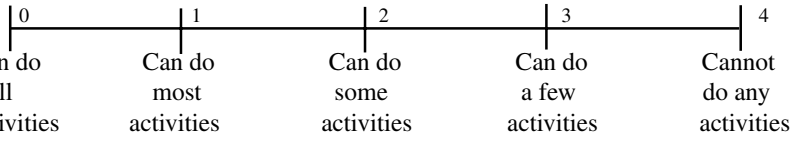
4. Travel (driving, etc.)



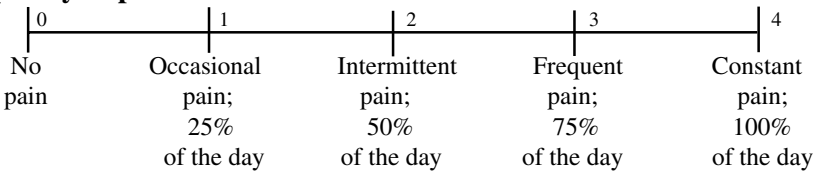
5. Work



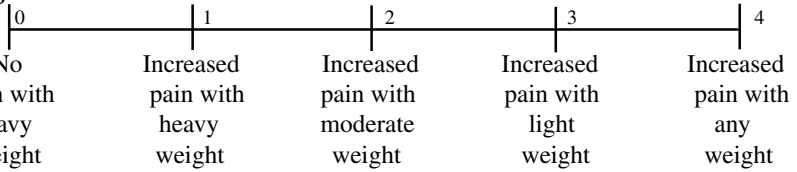
6. Recreation



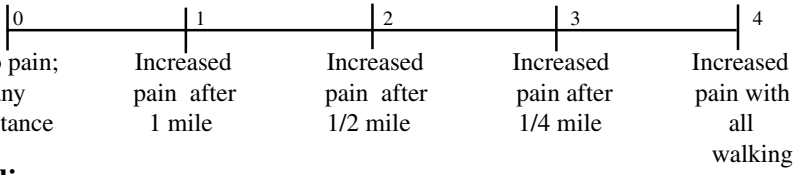
7. Frequency of pain



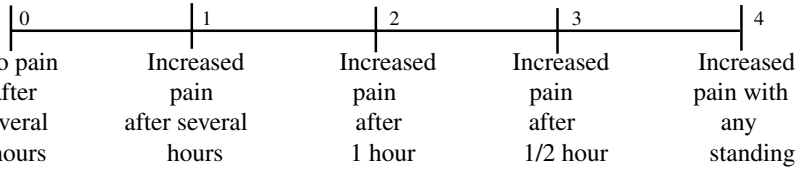
8. Lifting



9. Walking



10. Standing



Name _____
PRINTED

Total Score _____

_____
Signature

_____
Date

LAKEWOOD CHIROPRACTIC

NECK PAIN DISABILITY INDEX QUESTIONNAIRE

PLEASE READ*: This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage your everyday activities. Please answer each section by circling the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may relate to you, but *PLEASE JUST CIRCLE THE ONE. CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.

SECTION 1 - Pain Intensity **A I have no pain at the moment.** **B The pain is very mild at the moment.** **C The pain is moderate at the moment.** **D The pain is fairly severe at the moment.** **E The pain is very severe at the moment.** **F The pain is the worst imaginable at the moment.**	***SECTION 6 - Concentration*** **A I can concentrate fully when I want to with no difficulty.** **B I can concentrate fully when I want to with slight difficulty.** **C I have a fair degree of difficulty in concentrating when I want to.** **D I have a lot of difficulty in concentrating when I want to.** **E I have a great deal of difficulty in concentrating when I want to.** **F I cannot concentrate at all.**
SECTION 2 -Personal Care (Washing, Dressing, etc.) **A I can look after myself normally without causing extra pain.** **B I can look after myself normally, but it causes extra pain.** **C It is painful to look after myself and I am slow and careful.** **D I need some help, but manage most of my personal care.** **E I need help every day in most aspects of self care.** **F I do not get dressed, I wash with difficulty and stay in bed.**	***SECTION 7 - Work*** **A I can do as much work as I want to.** **B I can only do my usual work, but no more.** **C I can do most of my usual work, but no more.** **D I cannot do my usual work.** **E I can hardly do any work at all.** **F I cannot do any work at all.**
SECTION 3 - Lifting **A I can lift heavy weights without extra pain.** **B I can lift heavy weights, but it gives extra pain.** **C Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on a table.** **D Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.** **E I can lift very light weights.** **F I cannot lift or carry anything at all.**	***SECTION 8 - Driving*** **A I can drive my car without any neck pain.** **B I can drive my car as long as I want with slight pain in my neck.** **C I can drive my car as long as I want with moderate pain in my neck.** **D I cannot drive my car as long as I want because of moderate pain in my neck.** **E I can hardly drive at all because of severe pain in my neck.** **F I cannot drive my car at all.**
SECTION 4 - Reading **A I can read as much as I want to with no pain in my neck.** **B I can read as much as I want to with slight pain in my neck.** **C I can read as much as I want to with moderate pain in my neck.** **D I cannot read as much as I want because of moderate pain in my neck.** **E I cannot read as much as I want because of severe pain in my neck.** **F I cannot read at all.**	***SECTION 9 - Sleeping*** **A I have no trouble sleeping.** **B My sleep is slightly disturbed (less than 1 hour sleepless).** **C My sleep is mildly disturbed (1-2 hours sleepless).** **D My sleep is moderately disturbed (2-3 hours sleepless).** **E My sleep is greatly disturbed (3-5 hours sleepless).** **F My sleep is completely disturbed (5-7 hours)**
SECTION 5 - Headaches **A I have no headaches at all.** **B I have slight headaches which come infrequently.** **C I have moderate headaches which come infrequently.** **D I have moderate headaches which come frequently.** **E I have severe headaches which come frequently.** **F I have headaches almost all the time.**	***SECTION 10 - Recreation*** **A I am able to engage in all of my recreational activities with no neck pain at all.** **B I am able to engage in all of my recreational activities with some pain in my neck.** **C I am able to engage in most, but not all of my recreational activities because of pain in my neck.** **D I am able to engage in a few of my recreational activities because of pain in my neck.** **E I can hardly do any recreational activities because of pain in my neck.** **F I cannot do any recreational activities at all.**

NAME: _____ DATE: _____ SCORE: _____

Vernon HT, Mior SA. The Neck Disability Index: a study of reliability and validity. J Manip Physiol Ther 1991;14:409-415.

The Beck Pain Function Scale (BPFS) of Stratford et al

Overview:
Stratford et al developed the Back Pain Function Scale (BPFS) to evaluation functional ability in patients with back pain. The authors are from McMaster University Appalachian Physical Therapy (Georgia) and Virginia Commonwealth University.

Measures:
(1) Any of your usual work housework or school activities

(2) Your usual hobbies recreational or sporting activities

(3) Performing heavy activities around your home

(4) Bending or stooping

(5) Putting your shoes or socks (or stockings or pantyhose)

(6) Lifting a box of groceries from the floor

(7) Sleeping

(8) Standing for 1 hour

(9) Walking 1 mile

(10) Going up or down 2 flights of stairs (about 20 steps)

(11) Sitting for 1 hour

(12) Driving for 1 hour

Responses	Points
Unable to perform activity	0
Extreme difficulty	1
Quite a bit of difficulty	2
Moderate difficulty	3
A little bit of difficulty	4
No difficulty	5

Total score= SUM (Points for all 12 measures)

Adjusted total score= (Total score) / 60

FOR OFFICE USE ONLY:

Interpretation:

- Minimum score: 0
- Maximum score: 60
- Maximum adjusted score: 1 (100%)
- The higher the score the greater the patient's functional ability

Total Score (Adjusted)	Interpretation
0 (0%)	Unable to perform any activity
60 (100%)	No difficulty in any activity

Performance (page 2098):

- Test-retest reliability:0.88
- Internal consistency: 0.93
- The score strongly correlates with the Roland-Morris questionnaire.

References:

Stratford PW Binkly JM et al. Development and initial validation of the Back Pain Functional Scale. Spine. 2000; 2: 2095-2102 (Appendix A page 2101)

Lakewood Chiropractic
2222 University Blvd. West
Jacksonville, Florida 32217
Ph: (904)733-7020 Fax: (904) 733-0119

To: Medical Records Department

I, _____ give full authorization to release my
Patient Printed Name

Records to: **Lakewood Chiropractic Clinic**. If you have any questions, please feel free to contact me at

The number listed below.

Thank you,

_____ _____
Patient Signature Date

_____ _____
Patient Phone (home/ work/ cell) Date of Birth

If you have any questions or concerns for the office you may contact, **Melanie** @ (904) 733-7020

Lakewood Chiropractic
2222University Blvd. West
Jacksonville, FL 32217
Ph: 904-733-7020, Fax 904-733-0119

Dr. David Edenfield Dr. Steven Warfield

This form is for <u>females only</u>

I_____ have discussed on today's date the danger of X-rays to fetal tissue with Dr. David Edenfield.

To the best of my knowledge I am not pregnant and I consent to having the X-rays that Dr. Edenfield has ordered.

Patient Name: _____Date: _____

Lakewood Chiropractic
2222 University Blvd West
Jacksonville, FL 32217
Ph: 904-733-7020, Fax: 904-733-0119

POWER OF ATTORNEY AND MEDICAL RELEASE

POWER OF ATTORNEY TO ENDORSE CHECKS AND/OR TO SIGN ANY PIECE OF PAPER WHICH WILL ENHANCE OR EXPEDITE PAYMENT TO PROVIDER FOR SERVICES RENDERED, INCLUDING BUT NOT LIMITED TO A RELEASE OF MEDICAL RECORDS and ASSIGNMENT OF BENEFITS/AUTHORIZATION TO PAY.

Know by all these present that: The undersigned has made, constituted and appointed, and by these present does hereby make constitute and appoint LAKEWOOD CHIROPRACTIC, and any of its duly authorized agents and employees as and to be the undersigned's true and lawful attorney for and in the undersigned's name, place and steed to endorse any and all checks, drafts or money orders which are made payable to the undersigned alone or to the undersigned and the said LAKEWOOD CHIROPRACTIC, which checks, drafts or money orders are made payable for services which have been made by LAKEWOOD CHIROPRACTIC, at the request or with the knowledge and approval of the undersigned and/or the maker of check, draft of money order.

Furthermore, the undersigned allows LAKEWOOD CHIROPRACTIC or any of its agents to sign any papers that will be necessary to enhance, expedite and/or allow payment to said provider. This may include affidavits of non-ownership of vehicles, insurance forms, and other statements.

The undersigned by these present does give and grant said LAKEWOOD CHIROPRACTIC as attorney the full power and authority to do and perform all and every act 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 checks are concerned as well as any other documents.

MEDICAL RELEASE

A photocopy of this document shall be sufficient to authorized any person having records of medical treatment, services, or supplies pertaining to me to release true copies of same to LAKEWOOD CHIROPRACTIC or any insurer providing coverage to me in connection with the processing of any claim for benefits made by me or by the assignee herein. A photocopy of this document shall be as findings as an original signature page.

The undersigned does hereby ratify and confirm any and all actions taken by the said attorney in accordance with this special power and which the said attorney shall do or cause to be done by virtue of the present.

ASSIGNMENT OF BENEFITS

I, _____, Hereby authorize_____
(Name of Insured/Patient) (Name of Insurance Carrier)
to make medical benefits payments otherwise payable to me for services rendered by LAKEWOOD CHIROPRACTIC, but not to exceed the charges of those services, payable to and mailed directly to

Lakewood Chiropractic
2222 University Blvd West
Jacksonville, FL 32217

Furthermore, I hereby IRREVOCABLY ASSIGN to LAKEWOOD CHIROPRACTIC the rights and benefits under any policy of insurance, indemnity agreement, or any other collateral source as defined in Florida Statues for any service and or charges provided by LAKEWOOD CHIROPRACTIC. I hereby instruct the insurance carrier that in the event the subject medical benefits are disputed for any reason, including medical reasonableness and/or necessity, that the amount of unpaid benefits claimed by LAKEWOOD CHIROPRACTIC is to be set aside and not disbursed until the dispute is resolved.

In Witness whereof the undersigned have hereunto set their hands, this _____day of _____.

_____ _____
PATIENT'S SIGNATURE PATIENT'S NAME (PRINT PLEASE)

Lakewood Chiropractic
2222 University Blvd West
Jacksonville, FL 32217
Ph: 904-733-7020, Fax: 904-733-0119

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Lakewood Chiropractic
2222 University Blvd West
Jacksonville, FL 32217

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In Witness whereof the undersigned have hereunto set their hands, this _____day of _____.

_____ _____
PATIENT'S SIGNATURE PATIENT'S NAME (PRINT PLEASE)

Lakewood Chiropractic
2222 University Blvd West
Jacksonville, FL, 32217
Ph: 904-733-7020, Fax: 904-733-0119

Dr. David Edenfield, D.C. Dr. Steven Warfield, D.C

Notice of Doctor's Lien

I do authorize Lakewood Chiropractic to furnish you, my attorney, with a full report of his examination, diagnosis, treatment and prognosis, etc. of myself in regards to the accident in which I was recently involved.

I hereby authorize and direct you, my attorney, to pay directly to said doctor such as may be due and owing him for medical service rendered to me, both by reason of any other bills that are due to this office and to withhold such sums from any settlement, judgement or verdict as may be necessary to adequately protect said doctor. And I hereby further give a lien on my case to said doctor against any and all proceeds of my settlement, judgement, 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 agree never to rescind this document and that a recession will not be honored by my attorney. I hereby instruct that in the event another attorney is substituted in this manner, the new attorney honor this lien as inherent to the settlement and enforceable upon the case if it were executed by him.

I fully understand I am directly and fully responsible to said doctor for all medical bills submitted by him for service rendered me and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, judgement, or verdict by which I may eventually recover said fee.

Please acknowledge this letter by signing below and returning to the doctor's office. I have been advised that if my attorney does 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.

Patient's Signature: _____Date: _____

The Undersigned being attorney of the record for the above patient does hereby agree to observe all the terms of the above and agree to withhold such from any settlement, judgment, or verdict as any be necessary to adequately protect said doctor above named. Attorney further agrees that in the event this lien is litigated, the preventing party will be awarded attorney's fees and costs.

Attorney Signature: _____Date: _____

LAKEWOOD CHIROPRACTIC
2222 University Blvd. West, Jacksonville, FL 32217
Telephone (904) 733-7020

NOTICE OF WAIVER AND RELEASE CONCERNING MEDICAL NEGLIGENCE INSURANCE.

THIS AGREEMENT is made between LAKEWOOD CHIROPRACTIC, their physicians, agents, employees, servants, or any of the foregoing, referred hereinafter as "Doctor" and _____, referred to hereinafter as the "Patient". It is the intention of the parties to this agreement to bind not only themselves, but also their heirs, personal representatives, guardians or any persons deriving claims through or on behalf of the patient.

It is understood by the patient the he or she is not required to use the aforesaid practice or any physician named for physical medicine and that there are numerous other physicians in Northeast Florida who are qualified to do physical medicine.

It is further understood, that in the event of any controversy or dispute, which might arise between the Doctor and the patient, regardless of whether the dispute concerns the medical care rendered, including any negligence claim relating to the diagnosis, treatments or care of the patient, or payment of medical fees, or any other matter whatsoever, then the parties agree that the dispute shall be resolved by arbitration as provided by the Florida Arbitration Code, Chapter 682 (Florida Statutes). This arbitration shall be in lieu and instead of any trial by Judge or Jury. Each party shall choose one arbitrator and the two arbitrators shall choose a third arbitrator. The panel of arbitrators shall hear and decide the controversy, and the decision shall be binding on all parties and may be forced by a court of law necessary.

In the event that either party to this agreement refuses to go forward with arbitration, the party compelling arbitration reserves the right to proceed with arbitration, the appointment of the arbitrator and hearings to resolve the dispute, despite the refusal to participate of the absence of the opposing party. The Arbitrator shall go forward with the arbitration hearing and render a binding decision without the participation of the party opposing arbitration or dispute his or her absence at the arbitration hearing.

<u>Limitation of Damages</u>
Patient agrees that in the event of any dispute with the Doctor, for any reason whatsoever, including any negligence claim relating to the diagnosis, treatment, or care of the patient, patient's non-economic damages shall be limited to a maximum, of $100, 000 per incident, and shall be calculated on a percentage basis with respect to capacity to enjoy life as provided by Florida Statutes Section 766.207. For example, if the patient's injuries resulted in a 50% reduction in his or her capacity to enjoy life, this would warrant an award of no more than $50, 000 in non-economic damages. This limit applies regardless of the number of claimants of defendants in the arbitration proceeding.

Under Florida Law physicians are required to meet certain financial and /or insurance obligations to patients regarding medical malpractice and/or medical negligence. A physician may either purchase medical negligence or otherwise demonstrate financial responsibility consistent with Florida law to cover claims for medical negligence up to a required statutory amount.

Your physicians have elected not to purchase insurance beyond that which is minimally required under Florida law. The purpose of this notice/waiver and release is specifically to condition the provision of care being rendered by your physician to you. On agreement that you will request, receive, and engage such care only if you waive any right to claim or bring an action against your physician for damages beyond the insured amount. By signing this document, you are knowledgably, fully, and forever waiving any and all rights you may have now or have in the future to claim damages against your physician or Lakewood Chiropractic in excess of the amounts for which the physician and Lakewood Chiropractic may be insured.

The patient has had an opportunity to read this Doctor-Patient-Agreement, or to have it read to him or her necessary. The patient understands English or has had the Doctor-Patient-Agreement translated for him of her by_____. The patient has had an opportunity to ask questions about this Doctor-Patient-Agreement. The patient understands this agreement and has no unanswered questions. The patient has not been coerced or compelled to sign the agreement and does so of his or her own free will. **BY SIGNING GTHIS AGREEMENT I ACKNOWLEDGE THAT I HAVE CAREFULLY READ, UNDERSTAND, AND AGREE TO THE ABOVE TERMS AND CONDITIONS.**

If you do not agree to this wavier and release you must signify such disagreement by refusing treatment and care offered by your physician and seeking another doctor for your health concerns.

Patient Signature: _____Date: _____

Patient, Guardian or Legal Representative Signature: _____

Representative of Lakewood Chiropractic: _____

General Informed Consent

1. The recommended treatments, benefits risks, and possible complications including alternative treatments have explained to me fully. All questions have been answered to my satisfaction.

2. I understand and acknowledge that no guarantees have been given to me as to the outcome of treatments by the physicians, therapist or employees of Lakewood Chiropractic.

3. I understand and acknowledge that there are inherent risk and potential complications of any treatments (including VAX-D) in the broad range of the practice of physical medicine, physical and massage therapy including but not limited to muscle soreness, muscle strain, increased pain, weakness, and paralysis.

4. A copy of this informed consent shall be as valid as the original.

_____ _____

Patient's Signature Date/Time

_____

Witness Signature

Assignment of Benefits, Authorization to Release Medical Information and Benefit Plan Documents, and Appointment of Authorization Representative

I the undersigned, acknowledge the physical therapy, chiropractic, or medical services and/or supplies (Services) will be or have been provided to me by Lakewood Chiropractic (Provider) and that I may be entitled to receive payment for these services under a health plan (the Plan) sponsored by my employer, or an individual insurance policy.

I irrevocably assign, convey, and transfer to Provider to the fullest extent permissible under the law all benefits, claims, demands, suits remedies, liens, guarantees, causes of action at law or in equity or other rights I may have relating to the services I have received or will receive from provider based on or arising out of my status as a participant or beneficiary in the plan and/or as an insured under any applicable insurance policy.
This Assignment of Benefits, Authorization to Release Medical Information and Benefit Plan Documents, and Appointment of Authorized Representative (Assignment) is in consideration for services to be provided. Continued willingness of provider to see me as a patient and/or efforts of provider to collect payment for services. Such assignment includes, but not limited to the right to bring claims under sections 502(a)(1), (a)(2), and/or (a)(3) of the Employee Retirement Income Security Act of 1974 as amended (ERISA).

I appoint provider to act as an authorized representative under the plan and/or insurance policy to submit benefit claims and appeal on my behalf. I authorize the release and disclosure of medical information necessary to process any claim for benefits and/or to bring any legal claims or pursue any rights subject to this agreement. I further authorize provider to initiate formal complaints to any state or federal agency that has jurisdiction over my benefits and to release and disclose my medical information relevant to such complaint. I authorize any plan administrator or other fiduciary insurer or my attorney to release to provider any and all documents and instruments governing the plan, insurance policy, and/or settlement information. Upon written request from provider in order to claim medical benefits, reimbursement, or any applicable remedies. I authorize the use of this form for any and all plan and/or insurance claim submissions. I agree to cooperate with provider in any attempts to pursue benefits, claims, demands, suits, remedies, liens, guarantees, causes of action at law or in equity or other rights subject to this assignment against my plan, fiduciaries, insurers, and/or any other party.

Should this agreement be prohibited in whole or in part, under any anti-assignment provision of my plan or insurance policy I request and direct an administrator of the plan or other responsible fiduciary functioning as an administrator to furnish to me and the provider the document setting forth such anti-assignment provision within 30 days of receipt of this assignment. This assignment shall be reasonably relied upon and such anti-assignment prohibition shall be waived to the extent permissible by law should such information not be provided. A penalty of up to $110.00 per day pursuant to ERISA section 502(c)(1) may be assessed against the administrator of the plan or other party acting in such capacity.

I understand and agree that I am finically responsible for all charges of provider and this assignment does not relieve me of any liability or responsibility for any and all charges incurred for services of provider. I further understand and agree that this assignment does not impose any obligation on provider to pursue benefits, claims, demands, suits, remedies, liens, guarantees, causes of action at law or in equity or other rights I may have relating to the services.

A photocopy of this assignment shall be considered as effective and valid as the Original.

I have read and fully understand this agreement.

_____ _____

Signature of Patient **Date**

Lakewood Chiropractic

_____ _____

Signature of Provider Representative

Trifold Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

Introduction

At Lakewood Chiropractic we are committed to treating and using protected health information about you responsibly. This notice of Health Information Practices describes the personal information we collect and how and when we use or disclose information. It also describes your rights as the relate to your protected health information. This notice is effective April 4, 2003, and applies to all protected health information as defined by federal regulations.

Understanding Your Health Record/Information

Each time you visit Lakewood Chiropractic, a record of your visit is made. Typically, this record contains your symptoms, examination, test results, diagnosis, treatment, and a plan for future care or treatment.
This information often referred to as your health or medical record serves as:

- **Basis for planning your care and treatment**
- **Means of communication among health professionals who contribute to your care**
- **Legal document describing the care you received**
- **Means by which you or a third-party payer can verify services billed were provided**
- **A tool in educating health professionals**
- **A source of data for medical research**
- **A source of information for public health officials charged with improving the health of this state and the nation**
- **A source of data for our planning and marketing**
- **A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve**

Understanding what is in your record and how your health information is used helps you to ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and to make more informed decisions when disclosing to others.

Your Health Rights

Although your health record is the physical property of Lakewood Chiropractic, the information belongs to you. You have a right to:

- **Obtain a paper copy of this notice of information practices upon request**
- **Inspect and copy your health record as provided for in 45 CFR 164.524**
- **Amend your health record as provided in 45 CFR 164.528**
- **Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528**
- **Request communications of your health information by alternative means or at alternative locations**
- **Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522**
- **Revoke your authorization to use or disclose health information except to extent that the action has already been taken**

Our Responsibilities

Lakewood Chiropractic is required to

- **Maintain the privacy of your health information**
- **Provide you with this notice as to your legal duties and privacy practices with respect to information we collect and maintain about you**
- **Abide by the terms of this notice**
- **Notify you if we are unable to agree to a requested restriction**
- **Accommodate reasonable request you may have to communicate health information by alternative means or at alternative locations**

We reserve the right to change or practices and to make the 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've supplied us, or if you agree we will email the revised notice to you.

We will not use or disclose your health information without your authorization except as described in this notice. We will also discontinue use or disclose your health information after we have received in written revocation of the authorization according to the procedures included in the authorization.

For More Information or to Report a Problem

If you have questions and would like additional information, you may contact the practice's staff at 904-733-7020.

If you believe your privacy right have been violated you can file a complaint with the practice's Privacy Officer or with your regional office for Civil Rights, U.S. department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights.

Example of Disclosure for Treatment, Payment and Health Operations

We will use your health information for treatment.

For example: Information obtained by a nurse, physician, or other member of your health care team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your health care team. Members of your health care team will then record the actions they took and their observations. In the way the physician will know how you are responding to treatment.

We will also provide your physician or a subsequent health care provider with a copy of various reports that should assist him or her in treating you once you are discharged from the hospital.

We will use your health information for payment.

For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you as well as your diagnosis, procedures, and supplies used.

We will use your health information for regular health operations.

For example: We will share your relevant health information with other providers involved in your care to assist in the coordination of your care. This may include specialist, hospital, clinics and other individuals or organizations prior to or after us who have provided you with health care.

Business associates: There are some services provided in our organization through contacts with business associates. Examples include physician services in the emergency department and radiology, certain laboratory test, and copy service used when making copies of your health record. When these services are contracted we may disclose your health information to our business associate so they can perform the job we have asked them to do and bill you or your third-party payer for services rendered. To protect your health information, we require the business associate to appropriately safeguard your information.

Directory: Unless you notify us that you object, we will use your name and location in the hospital, general condition, and religious affiliation directory purposes. This information may be provided to members of the clergy and, except for religious affiliation to other people who ask for your name
.
Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative or another person responsible for your care, your location, and general condition.

Communication with family: Health professionals using their best judgement may disclose to a family member, personal representative, close family friend, or any other person you identify health information relevant to that person's involvement in your care or payment related to your care.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Funeral Directors: We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

Organ procurement organizations: Consistent with applicable law, we may disclose health information to organ procurement organizations or their entities engaged in procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Marketing: We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

Fund raising: We may contact you as part of a fund raising effort.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product, and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Workers Compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Public Health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Law Enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Federal makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers, or the public.

ACKNOWLEDGEMENT FORM

Acknowledgement of Receipt of Privacy Notice

I have been presented with a copy of Lakewood Chiropractic's Notice of Privacy Policies, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction(s) concerning the use of my personal information:

_____
_____
_____
_____

Further, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

Signed: _____ Date: _____

If not signed by patient, please indicate relationship to patient (e.g., spouse)

Relationship: _____ Witnessed by: _____

If the patient refuses to sign, indicate your attempt to obtain a signature below

[ ] Patient refused to sign this Acknowledgement

Date: _____

Time: _____

Employee Name: _____