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: _____

☐ 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) _____
_____
_____

PATIENT INSURANCE INFORMATION:

Please check any and all insurance coverage you or your spouse has applicable in this case.

☐ Medicare	☐ Blue Shield	☐ Auto Accident
☐ Medicaid	☐ Major Medical	☐ Union Plan
☐ Blue Cross	☐ Worker's Compensation	☐ Other

Insurance Identification Number: _____

Medicare/Medicaid Identification Number: _____

Major Medical or Auto Insurance:

Date of Accident: _____
Insurance Company Name: _____
Adjuster: _____
Address/Phone:_____
Claim #: _____ Policy #: _____ Effective Date: _____

LEGAL INFORMATION:

Attorney Name & Address: _____

_____

Attorney Phone #: _____

*Person to contact in an emergency (Name and Phone #): _____

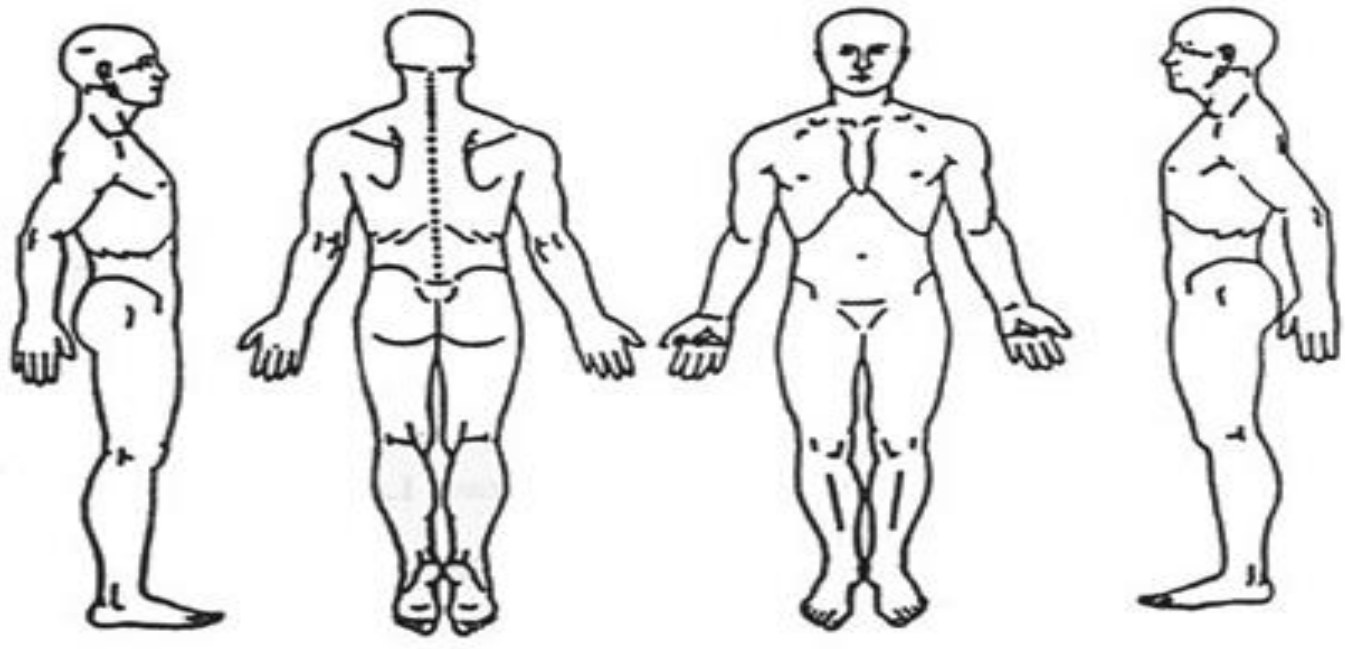
SUBJECTIVE PAIN LEVEL:

On a scale of 1-10 place an X in your current pain level

NORMAL	MILD PAIN	MODERATE PAIN	SEVERE PAIN	VERY SEVERE PAIN
( )0	( )1	( )4	( )7	( )10
	( )2	( )5	( ) 8	
	( )3	( )6	( )9	

Mark the area on your body where you feel the described sensations. Use the appropriate symbol. Mark stress areas of radiation. Include all affected areas.

Numbness	= = =	**Pin & Needles**	O O O	**Pain**	X X X
	= = =		O O O		X X X
	= = =		O O O		X X X



Name: _____Date: _____

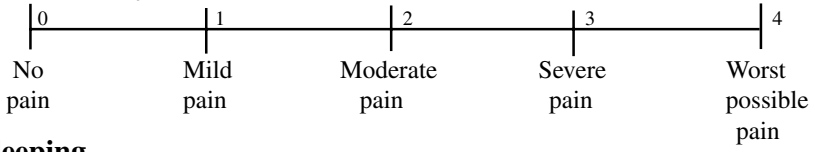
Patient's Signature: _____

Functional Rating Index

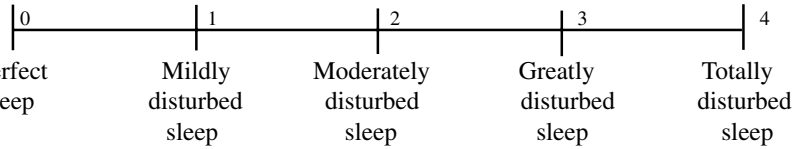
For use with **Neck and/or Back Problems** only.

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.**

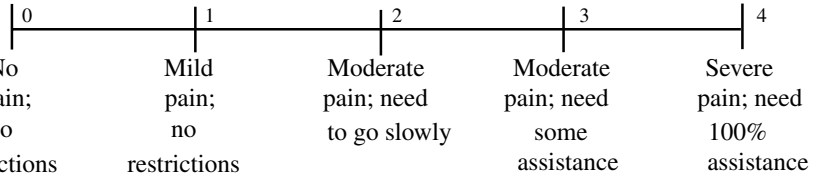
1. Pain Intensity



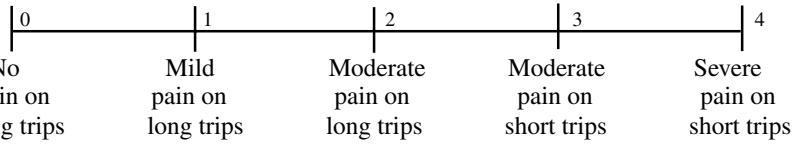
2. Sleeping



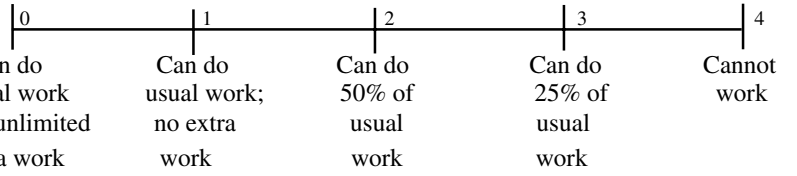
3. Personal Care (washing, dressing, etc.)



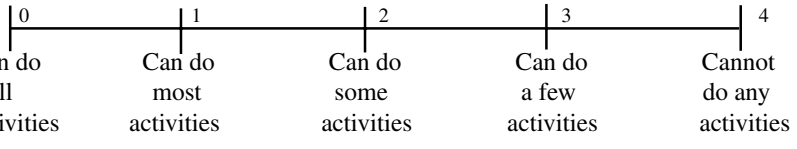
4. Travel (driving, etc.)



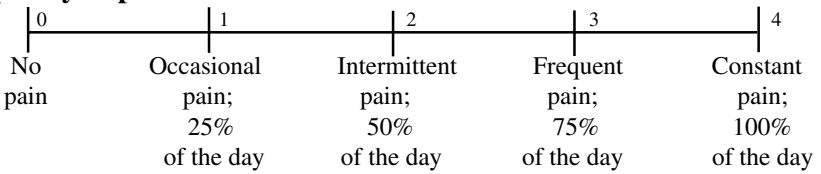
5. Work



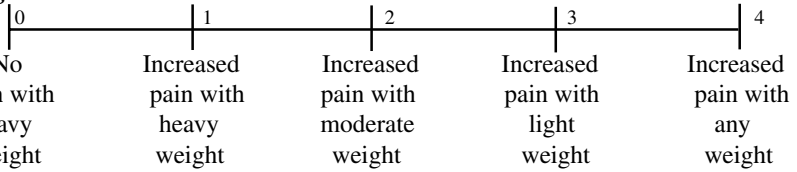
6. Recreation



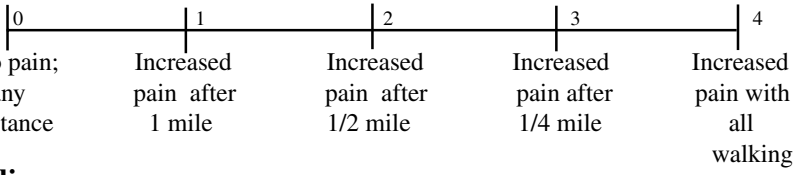
7. Frequency of pain



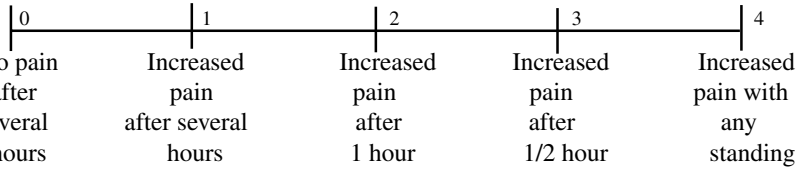
8. Lifting



9. Walking



10. Standing



Name _____
PRINTED

Total Score _____

_____
Signature

_____
Date

Lakewood Chiropractic
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 Medical Records to:
Patient Printed Name

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)

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.

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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. W., Jacksonville, FL 32217
(904)733-7020

Patient Name: _____

To the patient: Please read this entire document prior top signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything unclear.

The nature of the chiropractic adjustment

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may cause an audible "pop" or "click", much as you have experienced when you "crack" your knuckles.

You may feel sensitive movement.

Analysis/ Examination/ Treatment

As a part of the analysis, examination, and treatment, you are consenting to the following procedures:

__spinal manipulative therapy	__palpation	__vital signs
__range of motion testing	__orthopedic testing	__basic neurological testing
__muscle strength testing	__postural analysis	__EMS
__ultrasound	__hot/cold therapy	__radio graphic studies

__other (please explain) _____

The material risks inherent in chiropractic adjustment

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, muscle strains, cervical myelopathy, controvertible strains and separations, and burns. 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. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The availability and nature of other treatment options

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such
- Hospitalization
- Surgery

If you chose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary care physician.

The risks and dangers attendant to remaining untreated

Remaining untreated may allow the formation of adhesive and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less efficient the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. PLEASE CHECK THE APPROPRIATE BOX AND SIGN BELOW.

I have read ( ) or have had to read to me ( ) the above explanation of the chiropractic adjustment and related treatment. I have discussed with Dr. Edenfield and have had my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that is it in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Dated: _____ Dated: _____

Patients name: _____ Doctor's name: _____

Signature: _____ Signature: _____

Signature of parent or guardian (if a minor): _____

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.

Limitation of Damages

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 knowledgeably, 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

_____

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 **Date**

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 judgment 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

Acknowledgment 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 Acknowledgment

Date: _____

Time: _____

Employee Name: _____