ALIGN CHIROPRACTIC CENTER PIP INTAKE FORM

Patient History

Patient Name: _____

Home Address: _____ City _____ State _____ Zip _____

Home Telephone: _____ Work Phone: _____ Cell Phone: _____

Date Of Birth: _____ Age: _____ Social Security # _____

Marital Status: ☐Married ☐Single ☐Widow ☐Divorced Sex: ☐Male ☐Female E-Mail Address:_____

Information Provided By: ☐ Self ☐ Name: _____ Relationship: _____

Referred By: _____

PAST MEDICAL HISTORY

Have you ever had the same or similar condition prior to this accident?	☐Yes	☐No			
Have you ever been disabled?	☐Yes	☐No	If Yes: Please explain below		
Have you ever been involved in a prior auto accident?	☐Yes	☐No	If Yes: Were you injured?	☐Yes	☐No
Have you ever had any other type of accident (work, slip & fall, etc.)	☐Yes	☐No	If Yes: Were you injured?	☐Yes	☐No
Have you ever had a serious illness or injury prior to this loss?	☐Yes	☐No	If Yes: Please explain below		
Have you ever had any type of surgery?	☐Yes	☐No	If Yes: Please explain below		

Please explain all "Yes" answers: _____

_____

List all Medications:_____

HISTORY OF INJURY

Date of Accident _____ Year/Make & Model of car were in (or struck by) at time of loss: _____

Were you: ☐the Driver ☐a Pedestrian ☐ on a Bicycle ☐a Passenger in the… ☐Front Seat ☐Rear Left ☐Rear Middle ☐Rear Right

Were you wearing your seatbelt at time of loss? ☐Yes ☐No

Did your body strike any part of the vehicle? ☐Yes ☐No
If Yes- What part? ☐Dash ☐Pole/Pillar ☐Steering Wheel ☐Door ☐Window ☐Seat ☐Ground or Street ☐Other: _____

Did you hit your head?	☐Yes	☐No	
Were you cut or did you bleed?	☐Yes	☐No	If Yes: Where? _____
Did you lose consciousness?	☐Yes	☐No	
Were you bruised?	☐Yes	☐No	If Yes: Where? _____

What part/s of your body was injured? (Check off all that apply):

☐Head
☐Face
☐Neck
☐Upper Back
☐Mid Back
☐Lower Back
☐Chest
☐ Shoulder → ☐Left ☐Right
☐ Elbow → ☐Left ☐Right
☐ Hand → ☐Left ☐Right
☐ Leg → ☐Left ☐Right
☐ Knee → ☐Left ☐Right
☐ Foot → ☐Left ☐Right
☐ Fingers: → ☐Left ☐Right → ☐Thumb ☐Pointing ☐Middle ☐Ring ☐Pinky

Other Body Parts: _____

Please describe how accident occurred:

_____
_____
_____

CURRENT SYMPTOMS AND COMPLAINTS

List of all your current symptoms? _____

_____

_____

What do you do that helps ease your pain the most? _____

_____

Since the accident, have your symptoms become- ☐Worse ☐No Improvement ☐Improved Somewhat ☐Improved Greatly ☐Improved Completely

Effect of Activity on Pain: Please indicate if the following activities "increase", "decrease", or have "no effect"

Standing:	☐Increases Pain	☐Decreases Pain	☐No Effect on Pain	Comments: _____
Walking	☐Increases Pain	☐Decreases Pain	☐No Effect on Pain	Comments: _____
Sitting	☐Increases Pain	☐Decreases Pain	☐No Effect on Pain	Comments: _____
Bending	☐Increases Pain	☐Decreases Pain	☐No Effect on Pain	Comments: _____
Lifting	☐Increases Pain	☐Decreases Pain	☐No Effect on Pain	Comments: _____
Lying Down	☐Increases Pain	☐Decreases Pain	☐No Effect on Pain	Comments: _____
Coughing/Sneezing	☐Increases Pain	☐Decreases Pain	☐No Effect on Pain	Comments: _____
Arms above Head	☐Increases Pain	☐Decreases Pain	☐No Effect on Pain	Comments: _____
Working with Arms	☐Increases Pain	☐Decreases Pain	☐No Effect on Pain	Comments: _____
Turning Head	☐Increases Pain	☐Decreases Pain	☐No Effect on Pain	Comments: _____

What position or activity aggravates your pain the most? _____

HISTORY OF TREATMENT

Were you evaluated by paramedics at the scene of the accident? ☐Yes ☐No

Were you seen or treated in an emergency room after the accident? ☐Yes ☐No

Name of Hospital: _____ Date of Hospital Visit: _____ Time of Hospital visit: _____ ☐am ☐pm

How did you arrive to the emergency room? ☐Ambulance/EMS ☐Drove yourself ☐Family ☐Friend

Were you admitted to the hospital? ☐Yes ☐No Were you admitted for more than 1 day? ☐Yes ☐No

Explain the treatment you received at the hospital: _____

Please list the names of ALL medical providers you have seen since your accident:

DOCTOR'S NAME:				Still Treating with this Provider?		What was your Last Date of Treatment?
_____	☐DC	☐MD	☐Other	☐Yes	☐No	_____
_____	☐DC	☐MD	☐Other	☐Yes	☐No	_____
_____	☐DC	☐MD	☐Other	☐Yes	☐No	_____

Are you taking ANY medication (prescribed or not) for your injuries? ☐Yes ☐No If Yes: Medication: _____

Have you had any of the following tests performed as a result of the accident?

X-Rays ☐Yes ☐No Date: _____ Body Area: _____ Results: _____

CT Scan ☐Yes ☐No Date: _____ Body Area: _____ Results: _____

MRI ☐Yes ☐No Date: _____ Body Area: _____ Results: _____

EMG ☐Yes ☐No Date: _____ Body Area: _____ Results: _____

NCV ☐Yes ☐No Date: _____ Body Area: _____ Results: _____

Other (specify): _____ Date: _____ Body Area: _____ Results: _____

Have you received any of the following treatments? (Please indicate your response to these treatments):

Medical Treatment	☐Yes	☐No	☐Improved	☐No Effect	☐Worsened
Chiropractic Treatment	☐Yes	☐No	☐Improved	☐No Effect	☐Worsened
Massage Therapy	☐Yes	☐No	☐Improved	☐No Effect	☐Worsened
Home Exercises	☐Yes	☐No	☐Improved	☐No Effect	☐Worsened
TENS	☐Yes	☐No	☐Improved	☐No Effect	☐Worsened
Acupuncture	☐Yes	☐No	☐Improved	☐No Effect	☐Worsened
Injections of any Type	☐Yes	☐No	☐Improved	☐No Effect	☐Worsened
Surgery	☐Yes	☐No	☐Improved	☐No Effect	☐Worsened
Physical Therapy**	☐Yes	☐No	☐Improved	☐No Effect	☐Worsened

(** Physical Therapy includes heat treatments, ultrasound, electrical muscle stimulation, diathermy, ice)

Other (Explain): _____

EMPLOYMENT HISTORY

Were you employed on date of accident? ☐Yes ☐No List the NAME, ADDRESS & PHONE number for your employer on the following line:

Employer: _____ Phone #: _____

What is your occupation? _____ Did you miss any work due to the accident? ☐Yes ☐No If Yes- How many Days? _____

What is your job description? _____

Do you have any work restrictions? ☐Yes ☐No If Yes- What are they? _____

Do you have more than one job or employer? ☐Yes ☐No (If Yes- Please use the last 3 lines at the end of this section to explain your other jobs)

If you were <u>unemployed</u>, were you on disability at the time of the accident? ☐Yes ☐No If Yes- Please explain the nature and length of your disability below:

_____

_____

_____

Your signature below confirms that you have verified your answers and that each is truthful and complete.

X _____ Date: _____

Patient Signature

X _____

Parent/Guardian Signature

ACTIVITIES OF LIFE

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

ACTIVITIES:	EFFECT:			
Carry Children/Groceries	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sit to Stand	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Climb Stairs	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Pet Care	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Extended Computer Use	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Lift Children/Groceries	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Read/Concentrate	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Getting Dressed	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Shaving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sexual Activities	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sleep	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Static Sitting	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Static Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Yard work	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Walking	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Washing/Bathing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sweeping/Vacuuming	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Dishes	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Laundry	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Garbage	☐ No Effect	☐ Painful (can do)	☐ Painful (limits	☐ Unable to Perform
Driving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Other: _____	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform

List Prescription & Non-Prescription drugs you take: _____

_____

_____

Patient signature: _____ **Today's Date:** __/__/__

Continues on next page

REVIEW OF SYSTEMS

Please mark **P** for in the **Past, C** for **Currently** have, or **N** for **Never**

___ Headache	___ Pregnant (Now)	___ Dizziness	___ Prostate Problems	___ Ulcers
___ Neck Pain	___ Frequent Colds/Flu	___ Loss of Balance	___ Impotence/Sexual Dysfun.	___ Heartburn
___ Jaw Pain, TMJ	___ Convulsions/Epilepsy	___ Fainting	___ Digestive Problems	___ Heart Problem
___ Shoulder Pain	___ Tremors	___ Double Vision	___ Colon Trouble	___ High Blood Pressure
___ Upper Back Pain	___ Chest Pain	___ Blurred Vision	___ Diarrhea/Constipation	___ Low Blood Pressure
___ Mid Back Pain	___ Pain w/Cough/Sneeze	___ Ringing in Ears	___ Menopausal Problems	___ Asthma
___ Low Back Pain	___ Foot or Knee Problems	___ Hearing Loss	___ Menstrual Problem	___ Difficulty Breathing
___ Hip Pain	___ Sinus/Drainage Problem	___ Depression	___ PMS	___ Lung Problems
___ Back Curvature	___ Swollen/Painful Joints	___ Irritable	___ Bed Wetting	___ Kidney Trouble
___ Scoliosis	___ Skin Problems	___ Mood Changes	___ Learning Disabilty	___ Gall Bladder Trouble
___ Numb/Tingling arms, hands, fingers		___ ADD/ADHD	___ Eating Disorder	___ Liver Trouble
___ Numb/Tingling legs, feet, toes		___ Allergies	___ Trouble Sleeping	___ Hepatitis (A,B,C)

Pain Disability Questionnaire

The Pain Disability Questionnaire is used in Chapter 3 Pain (6th ed, 43-44) and Chapter 17 Spine (6th ed, 599-600). The format provided utilizes a centimeter scale to score, however the size in the *Guides* does not correspond with the same scale. An alternative approach (illustrated below) provides easily administered and scored numerical scales.

Patient Name _____ Date _____

Instructions: These questions ask your views about how your pain now affects how you function in everyday activities. Please answer every question and mark the ONE number on EACH scale that best describes how you feel.

1. Does your pain interfere with your normal work inside and outside the home?
Work normally — Unable to work at all
0 ------- 1 ------- 2 ------- 3 ------- 4 ------- 5 ------- 6 ------- 7 ------- 8 ------- 9 ------- 10

2. Does your pain interfere with personal care (such as washing, dressing, etc)?
Take care of myself completely — Need help with all my personal care
0 ------- 1 ------- 2 ------- 3 ------- 4 ------- 5 ------- 6 ------- 7 ------- 8 ------- 9 ------- 10

3. Does your pain interfere with your traveling?
Travel anywhere I like — Only travel to see doctors
0 ------- 1 ------- 2 ------- 3 ------- 4 ------- 5 ------- 6 ------- 7 ------- 8 ------- 9 ------- 10

4. Does your pain affect your ability to sit or stand?
No problems — Cannot sit /stand at all
0 ------- 1 ------- 2 ------- 3 ------- 4 ------- 5 ------- 6 ------- 7 ------- 8 ------- 9 ------- 10

5. Does your pain affect your ability to lift overhead, grasp objects, or reach for things?
No problems — Cannot do at all
0 ------- 1 ------- 2 ------- 3 ------- 4 ------- 5 ------- 6 ------- 7 ------- 8 ------- 9 ------- 10

6. Does your pain affect your ability to lift objects off the floor, bend, stoop, or squat?
No problems — Cannot do at all
0 ------- 1 ------- 2 ------- 3 ------- 4 ------- 5 ------- 6 ------- 7 ------- 8 ------- 9 ------- 10

7. Does your pain affect your ability to walk or run?
No problems — Cannot walk/run at all
0 ------- 1 ------- 2 ------- 3 ------- 4 ------- 5 ------- 6 ------- 7 ------- 8 ------- 9 ------- 10

8. Has your income declined since your pain began?
No decline — Lost all income
0 ------- 1 ------- 2 ------- 3 ------- 4 ------- 5 ------- 6 ------- 7 ------- 8 ------- 9 ------- 10

9. Do you have to take pain medication every day to control your pain?
No medication needed — On pain medication throughout the day
0 ------- 1 ------- 2 ------- 3 ------- 4 ------- 5 ------- 6 ------- 7 ------- 8 ------- 9 ------- 10

10. Does your pain force your to see doctors much more often than before your pain began?
Never see doctors — See doctors weekly
0 ------- 1 ------- 2 ------- 3 ------- 4 ------- 5 ------- 6 ------- 7 ------- 8 ------- 9 ------- 10

11. Does your pain interfere with your ability to see the people who are important to you as much as you would like?
No problem — Never see them
0 ------- 1 ------- 2 ------- 3 ------- 4 ------- 5 ------- 6 ------- 7 ------- 8 ------- 9 ------- 10

12. Does your pain interfere with recreational activities and hobbies that are important to you?
No interference — Total interference
0 ------- 1 ------- 2 ------- 3 ------- 4 ------- 5 ------- 6 ------- 7 ------- 8 ------- 9 ------- 10

13. Do you need the help of your family and friends to complete everyday tasks (including both work outside the home and housework) because of your pain?
Never need help — Need help all the time
0 ------- 1 ------- 2 ------- 3 ------- 4 ------- 5 ------- 6 ------- 7 ------- 8 ------- 9 ------- 10

14. Do you now feel more depressed, tense, or anxious than before your pain began?
No depression/tension — Severe depression / tension
0 ------- 1 ------- 2 ------- 3 ------- 4 ------- 5 ------- 6 ------- 7 ------- 8 ------- 9 ------- 10

15. Are there emotional problems caused by your pain that interfere with your family, social and or work activities?
No problems — Severe problems
0 ------- 1 ------- 2 ------- 3 ------- 4 ------- 5 ------- 6 ------- 7 ------- 8 ------- 9 ------- 10

Anagnostis C, Gatchel RJ, Mayer TG. The Pain Disability Questionnaire: A New Psychometrically Sound Measure for Chronic Musculoskeletal Disorders. *Spine* 2004; 29 (20): 2290-2302.

ALIGN
CHIROPRACTIC CENTER

DR. MICHAEL PARZYCH
8870 W. OAKLAND PARK BLVD. SUITE # 102, SUNRISE, FL.
33351 PHONE: (954) 748-3700 FAX: (954) 688-2523
EMAIL:**Office@alignchiropracticcenter.net**

PATIENT NAME: _____

DATE OF ACCIDENT: _____ / _____ / _____

IRREVOCABLE ASSIGNMENTS OF BENEFITS

IN CONSIDERATION FOR THE SERVICES RENDERED AND OTHER GOOD AND VALUABLE CONSIDERATION, THE RECEIPT AND SUFFICIENCY OF WHICH IS HEREBY ACKNOWLEDGED, I HEREBY IRREVOCABLY ASSIGN TO ALIGN CHIROPRACTIC CENTER. MY RIGHTS TO ANY AND ALL BENEFITS AND OVERDUE INTEREST ON SAID BENEFITS, COVERED UNDER ANY POLICY OF INSURANCE, INDEMNITY AGREEMENT, OR ANY OTHER COLLATERAL SOURCE AS DEFINED BY FLORIDA STATUTES. THIS ASSIGNMENT INCLUDES THE RIGHT TO FILE SUIT TO ENFORCE THESE ASSIGNED RIGHTS. THE UNDERSIGNED PATIENT ALSO DIRECTS THE INSURER TO PAY ALIGN CHIROPRACTIC CENTER DIRECTLY AND NOT TO INCLUDE MY NAME IN THE CHECK.

I FULLY UNDERSTAND THAT THIS ASSIGNMENT DOES NOT APPLY TO ANY DEDUCTIBLE, CO-PAYMENT OR CHARGES THAT EXCEED THE INSURANCE POLICY LIMITS AND THAT I REMAIN RESPONSIBLE TO ALIGN CHIROPRACTIC CENTER. FOR ANY SUCH PAYMENTS, AND THAT PAYMENT FOR SUCH CHARGES ARE NOT CONTINGENT ON ANY SETTLEMENT, JUDGEMENT OR VERDICT IN WHICH I MAY EVENTUALLY RECOVER MONEY DAMAGES.

CONSENT FOR TREATMENT

I HEREBY GIVE CONSENT FOR TREATMENT, CONSULTATION OR TESTING AS NECESSARY AND I ALLOW ALIGN CHIROPRACTIC CENTER. TO RELAESE ANY/ALL INFORMATION AS REQUIRED (INCLUDING BUT NOT LIMITED TO THE PIP PAYOUT SHEET).

AUTHORIZATION FOR RELEASE OF INFORMATION

I HEREBY AUTHORIZE ANY INSURANCE COMPANY FOR WHICH I MAY BE AN INSURED AND ANY OTHER MEDICAL PROVIDER FROM WHOM I HAVE IN THE PAST OR WILL IN THE FUTURE RECEIVED MEDICAL CARE OR TREATMENT TO RELEASE TO ALIGN CHIROPRACTIC CENTER. ANY/ALL CLAIM FILES, MEDICAL FILES, X-RAYS AND DIAGNOSTIC TESTS IN THEIR POSSESSION.

A PHOTO COPY OR FASCIMILE OF THIS DOCUMENT IS TO BE CONSIDERED AS VALID AS AN ORIGINAL.

DATE: _____ / _____ / _____ PATIENT SIGNATURE: _____

ALIGN
CHIROPRACTIC CENTER

DR. MICHAEL R. PARZYCH
8870 W. OAKLAND PARK BLVD. SUITE # 102, SUNRISE, FL. 33351
PHONE: (954) 748-3700 FAX: (954) 688-2523
EMAIL:**Office@alignchiropracticcenter.net**

Patient Records and Doctor's Lien

PATIENT : _____

DATE OF ACCIDENT : _____

I do hereby authorize Align Chiropractic Center to furnish you, my attorney, with a full report of his/her examination, diagnosis, treatment, prognosis, etc. of myself in regard to the accident in which I was recently involved.

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing said doctor for medical service rendered to me both by reason of this accident and by reason of any other bills that are due the doctor's office and to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect and fully compensate said doctor. And, I hereby further give a lien on my case to said doctor against any and all proceeds of my settlement, judgment, or verdict which may be paid to you, my attorney, or myself, as a result of the injuries for which I have been treated or injuries in connection therewith.

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

I agree to promptly notify said doctor of any change or addition of attorney(s) used by me in connection with this accident, and I instruct my attorney to do the same and to promptly deliver a copy of this lien to any such substituted or added attorney(s).

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, subject to a 1 percent per month service charge.

Dated: _____ _____

CLIENT

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

Dated: _____ _____

ATTORNEY

CHIROPRACTIC INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic procedures, including various modes of physical therapy/physiotherapy, diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with, or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures.

I understand that chiropractic adjustments and supportive treatment are designed to reduce and/or correct subluxations, allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, I understand and am informed that, as is with all healthcare treatments, results are not guaranteed, and there is no promise to cure. In addition, I understand and am informed that, as is with all healthcare treatments, in the practice of chiropractic there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns from heat lamps, ice or heating devices, fractures, disc injuries, strokes, dislocations and sprains. do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but are not limited to, self-administered, over-the-counter analgesics and rest; medical care with prescription drugs, such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and to secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

I understand that all payment(s) for treatment(s) are final and no refunds will be issued. However, prorated fees for unused, prepaid treatments will be refunded if I wish to cancel the treatment.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below, I agree to the above-named procedures. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

CHIROPRACTOR NAME:

(Date)

PATIENT SIGNATURE **X**

(Or Patient Guardian/Parent/Representative)

(Provide name and relationship if signing for patient)

ALSO SIGN THE ARBITRATION AGREEMENT ON REVERSE SIDE

PATIENT NAME:

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, including whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly negligently or incompetently rendered, will be determined by submission to arbitration as provided by state and federal law, and not by a lawsuit or resort to court process, except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury and instead are accepting the use of arbitration. Further the parties will not have the right to participate as a member of any class of claimants, and there shall be no authority for any dispute to be decided on a class action basis. An arbitration can only decide a dispute between the parties and may not consolidate or join the claims of other persons who have similar claims.

Article 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, as to whether this agreement is unconscionable, and any procedural disputes, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers, preceptors, or interns who now or in the future treat the patient while employed by working or associated with or serving as a back-up for the health care provider including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages. This agreement is intended to create an open book account unless and until revoked.

Article 3: Procedures and Applicable Law· A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days, and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator together with other expenses of the arbitration incurred or approved by the neutral arbitrator not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit. Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator

The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration. The parties agree that provisions of state and federal law, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law limiting the right to recover non-economic losses, and the right to have a judgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: General Provision: All claims based upon the same incident, transaction, or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1 on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and, if not revoked, will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment), patient should initial here. _____. Effective as of the date of first professional services.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below I acknowledge that I have received a copy

NOTICE. BY SIGNING THIS CONTRACT, YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION, AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT

PATIENT SIGNATURE **X** (Date)

(Or Patient Representative (Indicate relationship if signing for patient)

OFFICE SIGNATURE **X** (Date)

ALSO SIGN THE INFORMED CONSENT ON REVERSE SIDE

NCC-FED

C2004

Informed Consent

REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risk are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at **Align Chiropractic Center** have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

_____ ____/____/____  *Witness Initials*

Patient or Authorized Person's Signature Date

REGARDING: X-rays/Imaging Studies

FEMALES ONLY → *please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.*

☐ The first day of my last menstrual cycle was on ____-____-____ (Date)

☐ I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

_____ ____/____/____  *Witness Initials*

Patient or Authorized Person's Signature Date

ALIGN CHIROPRACTIC CENTER NOTICE OF PRIVACY PRACTICE

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

PERMITTED DISCLOSURES:

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

YOUR RIGHTS:

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

COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information, please call Ozner Family Chiropractic at 954-608-0436. If he is unavailable, you may make an appointment with our receptionist to see him within 72 hours or 3 working days. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Ave. SW
Room 509F HHH Building
Washington DC 20201

Patient initials: **_____-retaining *page 1 of 2***

OZNER FAMILY CHIROPRACTIC NOTICE REGARDING YOUR RIGHT TO PRIVACY continued…

I have received a copy of the Align Chiropractic Center Patient Privacy Notice. I understand my rights as well as the practice's duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this "Notice of Privacy Practice" at a time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware that a more comprehensive version of this "Notice" is available to me and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

Patient's Name	DOB
Patient's Signature	Date
Witness	Date

Medical Information Release Form
(HIPAA Release Form)

Name: _____ **Date of Birth:** _____

Release of Information:
[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse _____

[ ] Child(ren) _____

[ ] Other _____

[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages:
Please call [ ] my home [ ] my work [ ] my mobile number: _____

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] _____

The best time to reach me is (*day*) _____ between (*time*) _____

Signed: _____ Date: _____

Witness: _____ Date: _____

OFFICE OF INSURANCE REGULATION
Bureau of Property & Casualty Forms and Rates

Standard Disclosure and Acknowledgement Form
Personal Injury Protection - Initial Treatment or Service Provided

The undersigned insured person (or guardian of such person) affirms:

1. The services or treatment set forth below were **actually rendered.** This means that those services have **already been provided.**

_____

_____

2. I have the right and the **duty to confirm** that the services have already been provided.

3. I was **not solicited** by any person to seek any services from the medical provider of the services described above.

4. The medical provider has **explained** the services to me for which payment is being claimed.

5. If I notify the insurer in writing of a billing error, I may be entitled to a portion of any reduction in the amounts paid by my motor vehicle insurer. If entitled, my share would be at least 20% of the amount of the reduction, up to $500.

Insured Person (patient receiving treatment or services) or Guardian of Insured Person:

Name *(PRINT or TYPE)*	Signature	Date

The undersigned licensed medical professional or medical director, if applicable, affirms the statement numbered 1 above and also:

A. I have **not solicited** or caused the insured person, who was involved in a motor vehicle accident, to be solicited to make a claim for Personal Injury Protection benefits.

B. The treatment or services rendered were explained to the insured person, or his or her guardian, **sufficiently** for that person to sign this form with informed consent.

C. The accompanying statement or bill is **properly completed** in all material provisions and all relevant information has been provided therein. This means that each request for information has been responded to **truthfully, accurately**, and in a **substantially complete** manner.

D. The coding of procedures on the accompanying statement or bill is proper. This means that **no service has been upcoded, unbundled**, or constitutes an invalid **or not medically necessary diagnostic test** as defined by Section 627.732 (15) and (16), Florida Statutes or Section 627.736(5)(b)6, Florida Statutes.

Licensed Medical Professional Rendering Treatment/Services or Medical Director, if applicable *(Signature by his/ her **own hand**):*

Name *(PRINT or TYPE)*	Signature	Date

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of Claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree per Section 817.234(1)(b), Florida Statutes.

Note: The **original** of this form must be furnished to the insurer pursuant to Section 627.736(4)(b), Florida Statutes and may **not** be electronically furnished. Failure to furnish this form may result in non-payment of the claim.

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