WELCOME

3 Locations to Serve You Better!

PINES WEST CHIROPRACTIC	EAST SIDE CHIROPRACTIC	MARTINEZ CHIROPRACTIC
18501 Pines Blvd., Suite 104	8228 Biscayne Blvd.	12821 S.W. 88 St.
Pembroke Pines, FL 33029	Miami, FL 33138	Miami, FL 33186

PATIENT INFORMATION

Patient:_____ Date:_____
Address:_____
City:_____ State:_____ Zip Code:_____
Sex: ❑ M ❑ F Age: _____ DOB: _____
❑ Single ❑ Married ❑ Widowed ❑ Divorced
Patient SS No._____ Occupation:_____
Employer:_____ Employer Phone No._____
Employer Address:_____
Spouse's Name:_____ Birthdate:_____
SS No._____ Occupation:_____
Spouse's Employer:_____
Children (Names & Ages)_____
Whom may we thank for referring you:_____

PHONE NUMBERS

Home:_____
Work:_____
Ext:_____
Best time to call_____
Cell Phone:_____
EMAIL _____

IN CASE OF EMERGENCY

Name:_____
Relationship:_____
Home #:_____
Work #:_____

INSURANCE

Who is responsible for this account?_____
Relationship to Patient_____
Insurance Co. Name_____
Group or Card No._____
Is Patient covered by additional insurance? ❑ Yes ❑ No
Subscriber's Name_____
Birthdate_____ SS No._____
Relationship to Patient_____
Insurance Co. Name_____
Insurance I.D. No._____

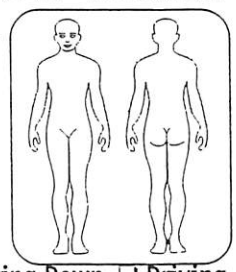
ACCIDENT INFORMATION

Is condition due to an accident?
❑ Yes ❑ No Date_____

Type of Accident?
❑ Auto ❑ Work ❑ Home ❑ Other
Explain Other:_____
If yes, please tell our front office and fill out correct accident form in addition to this form.

PATIENT CONDITION

Reason for Visit:_____ Preventive health check up: ❑ Yes ❑ No
When did your symptoms appear?_____ Is condition getting progressively worse? ❑ Yes ❑ No ❑ Unknown
Mark an X on the picture where you continue to have pain, numbness or tingling. →



Rate the severity of your pain on a scale of 1 (least pain) to 10 (severe pain) _____
Type of Pain: ❑ Sharp ❑ Dull ❑ Throbbing ❑ Numbness ❑ Aching ❑ Shooting ❑ Burning
❑ Tingling ❑ Cramps ❑ Stiffness ❑ Swelling ❑ Other
How many days in the last week did you feel the pain?_____ ❑ Is it constant or ❑ Occasional
Does it interfere with your ❑ Work ❑ Family Life ❑ Sleep ❑ Recreation ❑ Exercise
Activities or movements that are painful to perform ❑ Sitting ❑ Standing ❑ Walking ❑ Bending ❑ Lying Down ❑ Driving
Do you suffer from any other health conditions?_____

PAST HEALTH HISTORY

Please Check and Describe:
Major Surgery/Operations: ❑ Appendectomy ❑ Tonsillectomy ❑ Gall Bladder ❑ Hernia ❑ Back Surgery
❑ Broken Bones ❑ Other_____
Car accidents, falls, injuries:_____
Hospitalization (Other Than Above):_____
Previous Chiropractic Care: ❑ None ❑ Doctor's Name & Approximate Date of Last Visit_____
Drugs You Now Take: ❑ Nerve Pills ❑ Pain Killers/Muscle Relaxers ❑ Blood Pressure Medicine ❑ Insulin
❑ Other_____

Below are a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of chiropractic care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD OR CURRENTLY HAVE:

- ❑ Pneumonia
- ❑ Rheumatic Fever
- ❑ Polio
- ❑ Tuberculosis
- ❑ Whooping Cough
- ❑ Anemia
- ❑ Measles
- ❑ Chemical Dependency
- ❑ Alcoholism
- ❑ Mumps
- ❑ Small Pox
- ❑ Chicken Pox
- ❑ Diabetes
- ❑ Cancer
- ❑ Heart Disease
- ❑ Thyroid
- ❑ Asthma
- ❑ Aids/H.I.V.
- ❑ Influenza
- ❑ Pleurisy
- ❑ Arthritis
- ❑ Epilepsy
- ❑ Mental Disorders
- ❑ Lumbago
- ❑ Eczema
- ❑ Stroke
- ❑ Osteoporosis
- ❑ Weak Immune System
- ❑ Subluxations
- ❑ Pacemaker
- ❑ Multiple Sclerosis
- ❑ Psychiatric Care
- ❑ Hepatitis
- ❑ Hernia
- ❑ Carpal Tunnel Synd.
- ❑ Repetitive Strain Synd.

CHECK ANY OF THE FOLLOWING YOU HAVE HAD THE PAST SIX MONTHS:

MUSCULO-SKELETAL CODE

- ❑ Low Back Pain
- ❑ Pain Between Shoulders
- ❑ Neck Pain
- ❑ Arm Pain
- ❑ Joint Pain/Stiffness
- ❑ Difficult Chewing/Clicking Jaw
- ❑ General Stiffness
- ❑ Shoulder Pain
- ❑ Knee Pain
- ❑ Hip Pain
- ❑ Hand/Wrist Pain
- ❑ Foot/Ankle Pain

GENERAL CODE

- ❑ Fatigue
- ❑ Allergies
- ❑ Loss of Sleep
- ❑ Fever
- ❑ Headaches

C-V-R CODE

- ❑ Chest Pain
- ❑ Shortness of Breath
- ❑ Blood Pressure
- ❑ Irregular Heartbeat
- ❑ Heart Problems
- ❑ Lung Problems/Congestion
- ❑ Varicose Veins
- ❑ Ankle Swelling
- ❑ Stroke

GASTRO-INTESTINAL CODE

- ❑ Poor/Excessive Appetite
- ❑ Excessive Thirst
- ❑ Frequent Nausea
- ❑ Vomiting
- ❑ Diarrhea
- ❑ Constipation
- ❑ Hemorrhoids
- ❑ Liver Problems
- ❑ Gall Bladder Problems
- ❑ Weight Trouble
- ❑ Abdominal Cramps
- ❑ Gas/Bloating After Meals
- ❑ Heartburn
- ❑ Black/Bloody Stool
- ❑ Colitis

GENITO-URINARY CODE

- ❑ Bladder Trouble
- ❑ Painful/Excessive Urination
- ❑ Discolored Urine

MALE/FEMALE CODE

- ❑ Menstrual Irregularity
- ❑ Menstrual Cramps
- ❑ Vaginal Pain/Infection
- ❑ Breast Pain/Lumps
- ❑ Prostate/Sexual Dysfunction
- ❑ Venereal Disease
- ❑ Other Problems_____

_____

_____

NERVOUS SYSTEM CODE

- ❑ Nervous
- ❑ Numbness
- ❑ Paralysis
- ❑ Dizziness
- ❑ Forgetfulness
- ❑ Confusion/Depression
- ❑ Fainting
- ❑ Convulsions
- ❑ Cold/Tingling Extremities
- ❑ Stress

EENT CODE

- ❑ Vision Probers
- ❑ Dental Problems
- ❑ Sore Throat
- ❑ Ear Aches
- ❑ Hearing Difficulty
- ❑ Stuffed Nose

FAMILY HISTORY

The following members have the same or similar problems as I do:

- ❑ Mother
- ❑ Father
- ❑ Brother
- ❑ Sister
- ❑ Spouse
- ❑ Child

FEMALES ONLY

When was your last menstrual cycle?_____ Are you pregnant? ❑ Yes ❑ No ❑ Not Sure

EXERCISE

- ❑ None
- ❑ Moderate
- ❑ Daily
- ❑ Heavy

WORK ACTIVITY

- ❑ Sitting
- ❑ Computers
- ❑ Standing
- ❑ Light Labor
- ❑ Heavy Labor

HABITS

- ❑ Smoking Packs/Day_____
- ❑ Alcohol Drinks/Week_____
- ❑ Coffee/Caffeine Drinks Cups/Day_____
- ❑ High Stress Level

What is most important in your Doctor/Patient relationship?_____

_____

What are your health goals? ❑ pain relief only ❑ correct my health problem

Signature_____

WELCOME

AUTO ACCIDENT FORM

ABOUT YOU

Please Fill Out Completely

Name:_____

Today's Date:_____/_____/_____

WHAT WE NEED

Please present us with a copy of the police/accident report and/or medical records, hospital and/or Doctor's reports, diagnostic tests results, ex: MRI, C.T. Scans, X-Rays, others.

Thank You.

ACCIDENT INFORMATION

Date & Time of Accident _____ a.m. p.m.

Were you the: ❑ driver ❑ Front Passenger ❑ Rear Passenger

If a traffic violation was issued, to whom was it issued?

_____

Number of people in accident vehicle?_____

Name and addresses/phone no.'s of people in accident_____

_____

_____

Did the police come to the accident site? ❑ Yes ❑ No

Was a police report filed? ❑ Yes ❑ No

Were there any witnesses? ❑ Yes ❑ No

Were you wearing a seatbelt? ❑ Yes ❑ No

Was this vehicle equipped w/ airbags? ❑ Yes ❑ No

If yes, did they inflate? ❑ Yes ❑ No

In relation to the base of your skull, where was the headrest?

❑ Above ❑ Below ❑ At base of skull

What did your vehicle impact? ❑ Another Vehicle ❑ Other

If other, explain:_____

Did any part of your body strike anything in the vehicle?

❑ Yes ❑ No If yes, explain:_____

Did your vehicle go off the road?_____

Make and model of the vehicle your were occupying?_____

_____

Name of the location/street on which you were traveling?___

_____

In which direction were you headed? ❑ N ❑ S ❑ E ❑ W

What was the approx. speed of your vehicle?_____

Did the impact come from the : ❑ Rear ❑ Front ❑ Side

During the impact, were you facing:❑ Right ❑ Left ❑ Forward

Were you: ❑ Aware ❑ surprised by the impact?

If accident vehicle made impact with another vehicle what was Make & Model/Year of the other vehicle_____

Direction other vehicle was headed? ❑ N ❑ S ❑ W ❑ E

Speed of the other vehicle?_____

Briefly describe accident:_____

_____

_____

_____

Have you reported your accident to your auto insurance company? ❑ Yes ❑ No

ACCIDENT INFORMATION (cont.)

Did Accident render you unconscious? ❑ Yes ❑ No

If yes, for how long?_____

Please describe how you felt immediately after the accident:

_____

_____

Have you gone to a Hospital or seen any other Doctor?

❑ Yes ❑ No

When did you go?

❑ Just after accident ❑ Next day ❑ 2 days plus

How did you get there?

❑ Ambulance ❑ Private Transportation

Name of Hospital and/or Attending Doctor:_____

Was he/she a: ❑ Chiropractor ❑ M.D. ❑ Dentist

Describe any treatment you received:_____

_____

_____

Were X-rays taken? ❑ Yes ❑ No

Was medication prescribed? ❑ Yes ❑ No

Have you been able to work since this injury? ❑ Yes ❑ No

Are your work activities restricted as a result of this injury?

❑ Yes ❑ No

AUTO INSURANCE

Type of Insurance:_____

Company Name:_____

Address:_____

Phone No:_____

Insured's Name:_____

Policy No:_____ Claim No:_____

Insured's SS No:_____ DOB:_____

Insured's Employer:_____

Agent's Name:_____

List all automobiles owned by you or any family member living with you at the time of the accident:_____

_____

_____

Have you retained an attorney? ❑ Yes ❑ No

Name of attorney?_____ Phone:_____

Address:_____

City_____ State_____ Zip Code_____

*Patient's Signature*_____ *Date*_____

PINES WEST
CHIROPRACTIC
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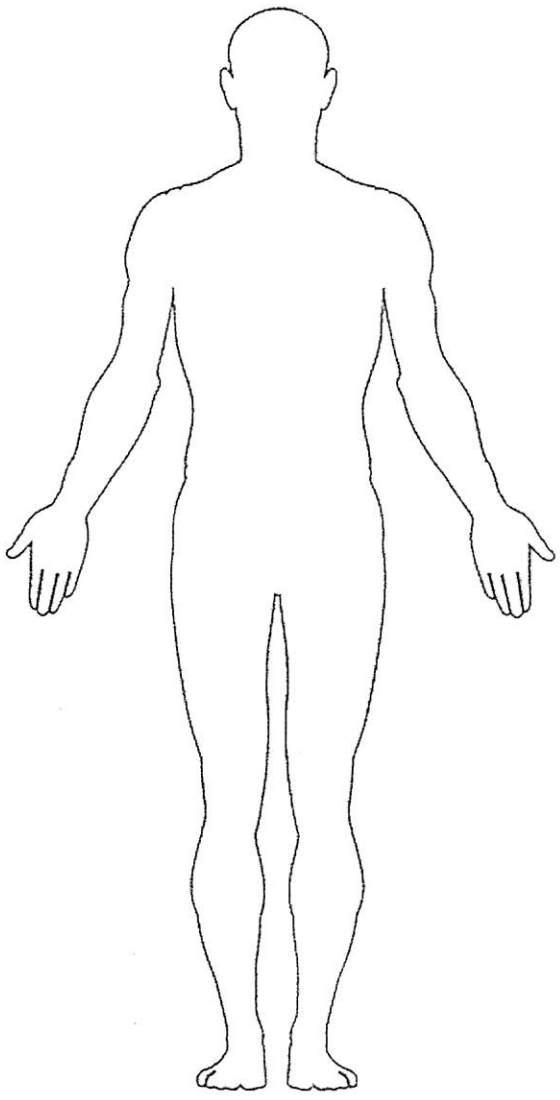
T: 954-432-3343 | F: 954-450-2565

Patient Name :_____ Date:_____ File:_____

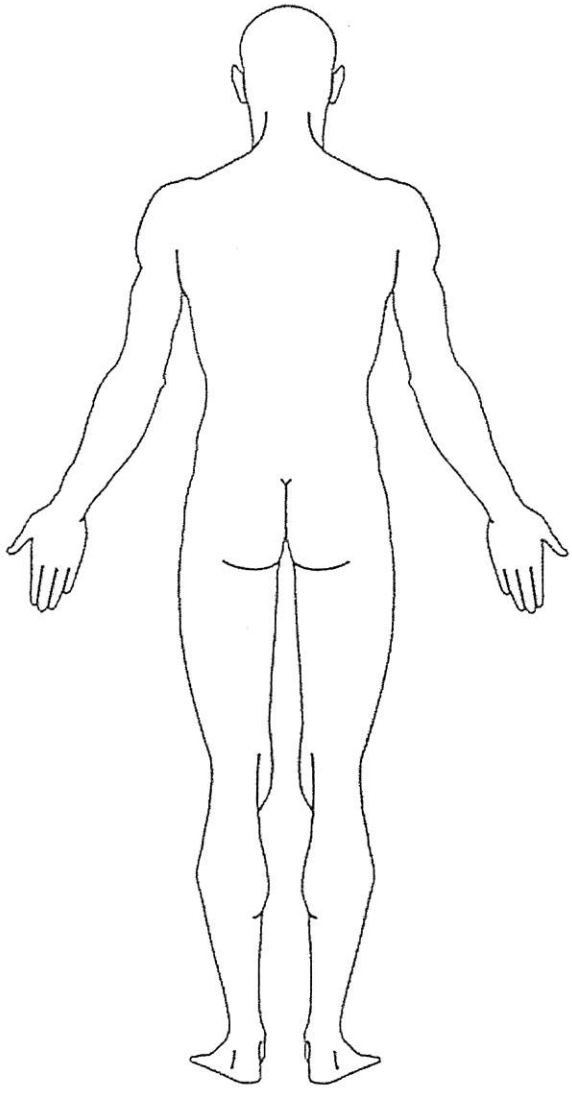
GENERAL SYMPTOMS CHART

Please use the following notations on the figures below to indicate the type and location of your symptoms, as it relates to the purpose of your visit today.

A = ACHE	G = STABBING	N = NUMBNESS
B = BURNING	M = SPASMS	T = TINGLING
P = PINS & NEEDLES	F = STIFFNESS	O = OTHER



FRONT



BACK

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PAIN DISABILITY QUESTIONNAIRE

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 — Can not 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 — Can not 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 — Can not 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 — Can not 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

Patient Signature _____

Doctor Signature _____

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INFORMED CONSENT FORM

I hereby request and consent to the performance of chiropractic treatments and other chiropractic/medical procedures, including various forms of physical therapy and diagnostic x-rays by Pines West Chiropractic Center. This consent is extended to other licensed chiropractic Physicians, Chiropractic assistants or licensed Massage Therapists, who now or in the future, are employed by, working with or associated with this office.

I certify that I have had the opportunity to discuss, with the doctor of Chiropractic and/or other office personnel, that nature and purpose of the care that is being provided. I understand that the results are not guaranteed. Further, I have been informed and I understand that, as in the practice of any of the healing arts, in the practice of Chiropractic, there are some risks to treatment including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I also understand that the doctor, who has explained all these things to me, is not expecting to be able to anticipate judgment during the course of care, based on the facts known at this time, and in my best interest.

My signature below certifies that I have read, or have had read to me the above consent. I also certify that I have had the opportunity to ask questions and options to care have explained. By signing this consent form, I agree to the care being provided to me for the entire course of treatment for my present condition(s) and for any future condition(s) for which I seek treatment.

_____	_____
Patient's Name (please print)	Witness' Name (please print)
_____	_____
Patient's Signature	Witness' Signature
_____	_____
Date Signed	Date Signed
_____	_____
Patient's Representative (If patient is a minor of if physically or mentally impaired)	Representative's relationship to Patient

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Irrevocable Assignment of Benefits/Policy Rights

I, the undersigned patient hereby assign the rights and benefits of insurance of applicable personal injury protections. Medical payment, and/or other insurance to **Pines West Chiropractic Center** of services and/or supplied rendered for treatment of personal injuries sustained in the accident of (DOA) _____ to the undersigned patient and covered by Personal Injury Protection (PIP Coverage of other insurance) coverage under _____ in accordance with Florida Statute 627.736(5). The undersigned agrees to pay any applicable deductible or co-payment not covered by the P.I.P. or other insurance coverage. I have read the information herein and is true and to the best of my knowledge.

This assignment includes, but is not limited to all rights to collect benefits directly from the insurance company for services that I have received; and all rights to proceed against the insurance company obligated to provide benefits in any action including legal suit, if any reason the insurance company fails to make payment of benefits of which I am due. Specifically, this assignment includes the right to collect payment for reasonable costs connected with coping and mailing records to the insurer at the insurer's request and in accordance with Florida Statute 627.736(6) . This assignment also includes any right to recover attorney's fees and cost for such action brought by the provider as Patient's assignee. I agree that **Pines West Chiropractic Center** may select any attorney he/she wishes and understand and agree that the attorney selected by them may be different than the attorney handling my personal injury/bodily claim or case.

As part of this assignment of right and benefits, 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 benefits claimed by **Pines West Chiropractic Center** is to be set aside and not disbursed until the dispute is resolved. As part of this assignment of rights and benefits, I further instruct the insurance carrier to notify the provider immediately of any dispute as to payment so that he/she may exercise their legal rights. I understand that any person who knowingly files anything containing any false, incomplete or misleading information with the intent to injure defraud, or deceive any insurance company is guilty of a felony of the third degree. I have read the information herein and it is true and correct to the best of my knowledge and belief.

_____ _____
Patient Signature Date

The undersigned on behalf of **Pines West Chiropractic Center** here by accepts assignment of the insurance right and benefits for the services rendered to: _____
And to be paid directly to **Pines West Chiropractic Center** Under

_____
Personal Injury Protection (PIP) or other insurance coverage with _____
And in accordance with the Florida Statute 627.736(5).

_____ 650705019
Provider Representative's Signature Tax ID#

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Official Certification of Patient as to Insurance Information

Insurance Carrier: _____

Policy #: _____

Insured: _____

Relationship
To Insured: _____

Date of Accident: _____

I, as the above captioned patient hereby attest that to the best of my knowledge, that the insurance claim/policy information I have provided above is in fact the correct insurance information under which I am entitled to medical and or PIP insurance coverage.

I understand that the medical provider is relying on this correct information in order to receive the appropriate coverage and qualify for payment for medical services provided to me.

_____ _____
Signature of Patient Date

This notice is sent in good faith so I may utilize the benefits stated in my PIP policy for which I have paid premiums or I am claiming benefits from.

If the claim or policy number listed above is not correct or your company is not able to match the insured you must notify the providers office within 5 business days or this information will be assumed correct and the providers office will not be prejudiced in its efforts collecting for services provided.

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Authorization Form

Pines West Chiropractic Center

Patient Authorization for Use and Disclosure of Protected Health Information

By signing, I authorize Pines West Chiropractic to use and/or disclose certain protected health information (PHI) about me to _____.

This authorization permits Pines West Chiropractic to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of services, type of services, level of detail to be released, origin of information, etc.)

The information will be used or disclosed for the following purpose:

(If disclosure is requested by the patient, purpose may be listed as "at the request of the individual")

The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire on _____.

The Practice will ___ will not ___ receive payment or other remuneration from third party in exchange for the using or disclosing the PHI.

I do not have to sign this authorization in order to receive treatment from Pines West Chiropractic Center. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the privacy officer at.

Pines West Chiropractic Center, 18501 Pines Blvd, Suite 104, Pembroke Pines, FL 33029
(954) 432-3343

I have received a copy of the "Notice of Privacy Practices" and have read it.

_____ _____
Signature of Patient or Legal Guardian Relationship to Patient

_____ _____
Print Patients Name Date

_____ _____
Print Name of Legal Guardian Date

Patient/Guardian must e provided with signed copy of the authorization form

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Patient Demographics

First Name: _____ Last Name _____

Language: check one
___ English
___ Spanish
___ Other please Specify _____

Race: check one
___ Decline to Specify
___ American Indian or Alaska Native
___ Asian
___ Black or African American
___ White
___ Other please specify _____

Ethnicity: check one
___ Decline to Specify
___ Not Hispanic or Latino
___ Hispanic or Latino

Smoking: check one
___ Current every day smoker
___ Ex-smoker
___ Never smoked

Religion: _____

Preferred Communication Type: check one
___ Phone
___ Email
___ Mail/letter

Mother's Maiden Name: First_____ Last _____

Cognitive Status: check one
___ Memory Impairment
___ No Memory Impairment
Cognitive Status Start Date_____

Functional Status: check one
___ Depends on Walking stick
___ No Impairment
Functional Status Start Date _____

****

Next of Kin: First Name _____ Last Name _____
Relationship: _____
Address: _____
_____

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Massage Therapy Policy to ALL Patients

In fairness to our office, massage therapists, and other patients, we have made the following policy pertaining to Massage Therapy Appointments.

- A minimum **24 hour** notice of cancellation is **REQUIRED**.
- A **$30 fee** will be charged directly to you for cancelling with a notice of less than 24 hours.
- This charge is your responsibility and **will not** be submitted to your insurance company.
- Children under age 16 cannot be left unattended while you are receiving a massage.

_____ _____

Patient Signature Date

Optional Appointment Reminder via Text or Email

Please choose an option:

☐ Text Message: Phone Number: _____

☐ Email: Address _____

Chiropractic Newsletter

Receive our interesting, health improving monthly newsletter online

This monthly Chiropractic Newsletter delivers credible and current health information to help you and your family live healthier and happier. Please fill out the information below for your authorization.

- ○ Yes, I would like to receive this monthly newsletter.
- ○ No, I would not like to receive this monthly newsletter.

Email: _____

Signature: _____

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Release of Medical Records

Pines West Chiropractic Centers
Dr. Joseph Buckley
18501 Pines Blvd
Suite 104
Pembroke Pines, Florida 33029

To whom it may concern:

Please release all records, including but not limited to progress notes, operative notes, laboratory test results, diagnostic tests, and x-rays.

I, _____ (please print) hereby authorize the release of my medical records as provided above.

_____

Patient Signature Date

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Irrevocable Lien

I do hereby authorize Pines West Chiropractic Center, Dr. Joseph Buckley, Dr. Damian Martinez, to furnish you my attorney, with full report of my examination, diagnosis, treatment, prognosis, etc., in regard to the accident in which I was involved.

I hereby authorize and direct you, my attorney, to pay directly to said facility such sums as may be due and owing for medical services rendered both by reason of this accident and by reason of any other bill that are due to this facility and to withhold such sums from the settlement, judgement or verdict as may be necessary to adequately protect said doctors. I hereby further give a lien on my case to said satisfy 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 fully understand that I am directly and fully responsible to said facility for all medical bills submitted for service rendered me and that this agreement is made solely for said facility's additional protection and in consideration of them awaiting payment. I further understand that such payment is not contingent on any settlement, judgement or verdict by which I may eventually recover said fee.

Patient's Signature: _____ Date: _____

The undersigned, being attorney of records for the above patient, does hereby agree to observe all terms of the above and agrees to withhold such sums from any settlement, judgement or verdict as may be necessary to adequately protect said facility above named.

Attorney's Signature: _____ Date: _____

HIPAA Notice of Privacy Practices

PINES WEST CHIROPRACTIC CENTER, INC.

18501 Pines Blvd, Ste 104 Pembroke Pines, FL 33029-1414

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

If you have any questions about the above notice, please contact our Office at

954-432-3343

Our Obligations

We are required by law to:

- Maintain the privacy of protected health information
- Give you the notice of your legal duties and privacy practices regarding health information about you
- Follow the terms of our notice that is currently in effect

How We May Use and Disclose Health Information

Described as follows are the ways we may use and disclose health information that identifies you ("Health Information"). Except for the following purposes,
we will use and disclose health information only with your written permission. You may revoke such permissions at any time by writing to our practice's
privacy officer.

Treatment. We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

Payment. We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company, or a third party for treatment and services you receive. For example, we may give your health plan information so that they will pay for your treatment.

Health Care Operations. We may use and disclose Health Information for health care operation purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care to operate and manage our office. For example, we may use and disclose information to make sure the obstetric or gynecologic care you receive is of the highest quality. We also may share information with our entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives, and Health Related Benefits and Services. We may use and disclose Health Information to contact you and remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health
related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who receive one treatment to those who receive another for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes.

Special Situations

As required by law. We will disclose Health Information when required to do so by international, federal, state, or

local law.
To Avert a Serious Threat to Health of Safety. We will disclose Health Information when necessary to prevent a serious threat to your health and safety or the public, or another person. Disclosure, however, will be made only to someone who may be able to help provide treatment.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or to provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than that as specific in our contract.

Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement; banking or transportation of organs, eyes, or tissues to facilitate organ, eye, or tissue donation, and transplantation.

Military and Veterans. If you are a member of the army forces, we may use or release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Worker's Compensation. We may release Health Information for worker's compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosure to prevent or control disease, injury, or disability; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; inform a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and report to the appropriate government authority if we believe a patient has been a victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required by law.

Health Oversight Activities. We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit of a dispute, we may disclose Health Information in response to a court or a court administrator order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release Health Information if asked by a law enforcement official if the information is: 1) in response to a court order, subpoena, warrant, summons, or similar process; 2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; 3) about the victim of crime even if, under certain circumstances, we are unable to obtain the person's agreement; 4) about a death we believe may be the result of criminal conduct; 5) about criminal conduct on our premises and; 6)in an emergency to report a crime to the location of the crime if victims, or the identity, description, or location of the person who committed the crime.

Coroners, Medical Examiners, Funeral Directors. We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release Health Information to funeral directors as necessary for their duties.

National Security and Intelligence Activities. We may release Health Information to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state, or to conduct special investigations.

Protective Services and Intelligence Activities. We may release Health Information to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state, or to conduct special investigations.

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or other custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be made if necessary 1) for the institution to provide you with health care; 2) to protect your health and safety or the health and safety of others, or; 3) for the safety and security of the correctional institution.

Your Rights

You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy. You have the right to inspect and copy Health Information that we may used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this information, you must make your request in writing, to our Privacy Officer.

Right to Amend. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to our Privacy Officer.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment, and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to our Privacy Officer.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operation. You also have a right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you can ask that we not share information about your particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to our Privacy Officer. **We are not required to agree with your request.** If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Right to Request Confidential Communication. You have the right to request that we communicate with you about your medical matters in a certain way or at a certain location. For example, you can ask that we contact you only by mail or at work. To request confidential communications, you must make your request, in writing, to our Privacy Officer. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You must ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice by contacting our office.

Changes to This Notice

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a current copy of our notice at our office. The notice will contain the effective date on the first page, in the top right hand corner.

Complaints

If you believe your privacy has been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact our Privacy Officer. All complaints must be made in writing. **You will not be penalized for filing a complaint.**

By Subscribing my name below, I acknowledge receipt of a copy of this notice, and my understanding and my agreement to its terms.

_____ _____

Patient Signature Date