REGISTRATION

Date: _____ Phone: _____

Patient: _____
Last Name First Name Initial

Street Address: _____

City/State/Zip Code: _____

Sex: [] M [] F Age: ____ Birth-date: _____ Height:____ _____Weight:_____

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

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

[] 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)*

_____ _____ _____
_____ _____ _____
_____ _____ _____

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 #): _____

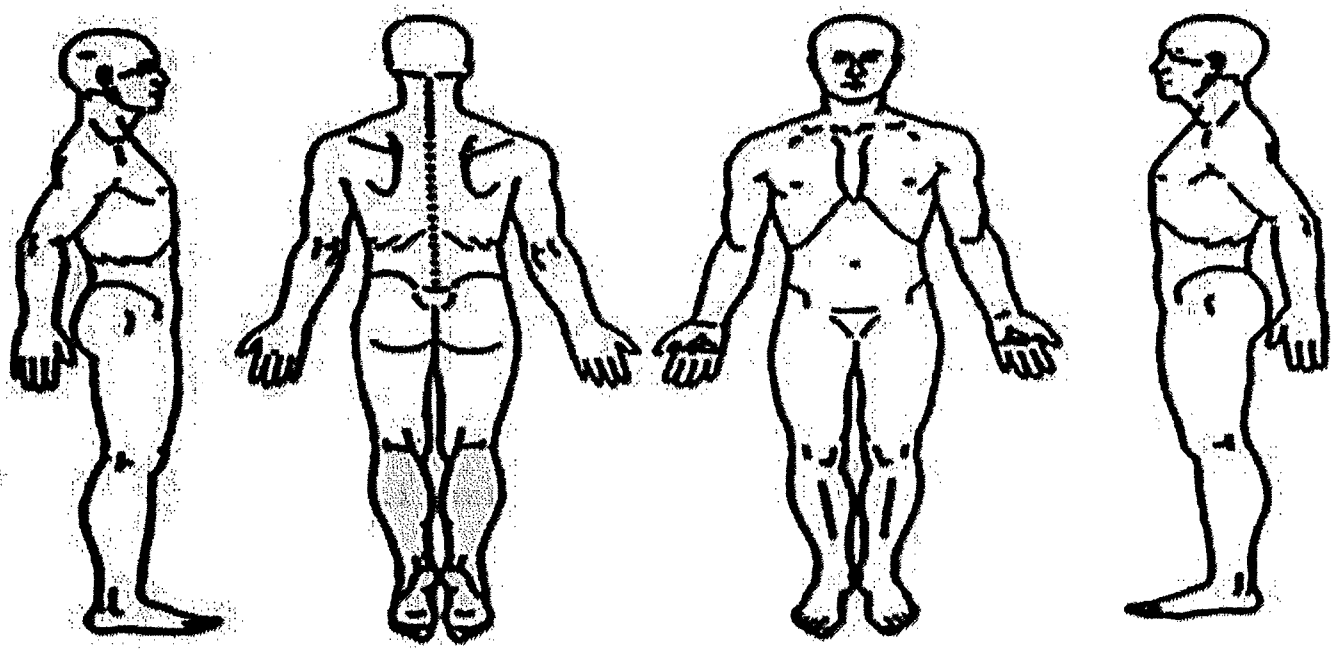
SUBJECTIVE PAIN LEVEL:

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: _____

Patient Name: _____ Date of Birth: _____

To the patient: Please read this entire document prior to signing. 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	__ palpitation	__ 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, 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 option
Other treatment options for your condition may include:

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

If you choose 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 BELOW UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. PLEASE CHECK THE APPROPRIATE BOX AND SIGN BELOW.

I have read ( ) or I have had read to me ( ) the above explanation of the chiropractic adjustment and related treatment. I have discussed this with Dr. Warfield 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 it is 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: _____

Patient Name: _____ Doctor's Name: _____

Signature: _____ Signature: _____

WARFIELD CHIROPRACTIC CLINIC INC.

3636 University Blvd S. Building C Jacksonville, FL. 32216

Phone: (904)659-5669 Fax: (904) 731-9270

NOTICE OF WAIVER AND RELEASE CONCERNING MEDICAL NEGLIGENCE INSURANCE

THIS AGREEMENT Is made between Warfield Chiropractic Clinic Inc, their Physicians, agents, employees, servants, or any of the foregoing, referred hereinafter as "Doctor" and _____, referred to hereinafter as "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 that he or she is not required to use the aforementioned 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 doctor and the patient, regardless of whether the dispute concerns the medical care rendered, including negligence claim relating to the diagnosis, treatments, or care of the patient, or payment 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 if 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.

Assignment of Benefits, Authorization to Release medical Information and Benefit Plan Documents, and Appointment of Authorization Representation

I the undersigned, acknowledge the physical therapy, chiropractic, or medical services and/or supplies (services) will be or have been provided to me by Warfield Chiropractic Clinic Inc. (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 or 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 the 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 the 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, reimbursements, or any applicable remedies. I authorize the use of this form for any and all plan and/or insurance claims submissions. I agree to cooperate with the 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 anti-assignment provision of my plan or insurance policy I request and direct 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 pe day pursuant to ERISA section 502(c)(1) may be assessed against the administrator of the plan or other party acting in such a capacity.

I understand and agree that I am financially responsible for all charges of the provider and this assignment does not relieve me of any liability or responsibility for any and all charges incurred for services of the 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 service.

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

Warfield Chiropractic Clinic Inc.

_____ _____

Signature of Provider Representative Date

WARFIELD CHIROPRACTIC CLINIC INC.

3636 University Blvd S. Building C

Jacksonville, Fl. 32216

Phone: (904)731-1711 Fax: (904)731-9270

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement.

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for Warfield Chiropractic Clinic Inc. this _____ day of _____, 20_____. A copy of this signed, dated Acknowledgement shall be as effective as the original.

_____

Please print your name

_____

Please sign your name

If you are the legal representative of the patient, please print the patient's name(s) and describe your authority _____.

Thank you.

OFFICE USE ONLY

As Privacy Official, I attempted to obtain the patient's (or representative's) signature on this Acknowledgement but did not because:

It was emergency treatment _____

I could not communicate with the patient _____

The patient refused to sign _____

The patient was unable to sign _____

_____

Signature of Privacy Official

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TO: MEDICAL RECORDS DEPARTMENT

I, _____ give full authorization to release my Medical Records to Warfield Chiropractic Clinic Inc. If you have any questions, please contact me at the number listed below.

Thank you,

_____ _____

Patient Signature Date

_____ _____

Patient Phone (home/cell) Date of Birth