Fralicker Chiropractic Clinic, Inc

835 Cesery Blvd.
Jacksonville, FL 32211

Date: _____

Patients Name: _____ Chief Complaint: _____

Address: _____ Home Phone: _____

City, State, Zip: _____ Cell Phone: _____

Social Security #: _____ Email: _____

Date of Birth: _____ May we email you monthly health newsletters? _____

Occupation: _____ Age: _____ Marital Status: M S W D

Employer: _____

Insurance Company: _____ Insurance ID#: _____

Insurance Phone #: _____ Name of the Insured: _____

Are your present symptoms or conditions related to or the result of an auto collision, work-related injury or other personal injury someone else might be responsible for? ___ Yes ___ No

Family Physician: _____ Name of Facility: _____

Person to contact in case of emergency (Name, phone, relation): _____

What operations have you had? _____ When? _____

_____ When? _____

Serious Illness: _____ When? _____

_____ When? _____

What medications or drugs are you taking? Please list all prescribed medications and supplements/vitamins.

Medication name: _____ Mg/dosage_____ Times taken daily _____

Medication name: _____ Mg/dosage_____ Times taken daily _____

Medication name: _____ Mg/dosage_____ Times taken daily _____

Medication name: _____ Mg/dosage_____ Times taken daily _____

Medication name: _____ Mg/dosage_____ Times taken daily _____

If you need more space, please continue list on the back.

What is your goal in our office? _____

By signing below, you indicate that all the information above is true and correct.

Patient/Guardian signature: _____ Date: _____

ASSIGNMENT OF BENEFITS, AUTHORIZATION TO SETTLE CLAIM AND DIRECTION TO PAY MEDICAL PROVIDER DIRECTLY

By my signature below, for good and valuable consideration (including but not limited to the extension of credit to me), I hereby assign, transfer and convey to **Fralicker Chiropractic Clinic, Inc** (hereinafter "the Provider") all of my rights, title and interest in and to medical expense reimbursement in whatever form, including but not limited to any automobile liability medical expense payments or other health benefits indemnification and/or agreement otherwise payable to me. This payment shall not exceed my indebtedness to the above named assignee and I acknowledge that I will timely pay any indebtedness owed by me to the assignee that is not otherwise satisfied by the above-mentioned assigned proceeds. I also acknowledge that any medical expenses not covered under my insurance policy will be my responsibility.

I further authorize the Provider to negotiate, collect and settle any claim with any insurance carrier or other third party payor with regard to these services, which authorization shall include authority to:
(1) request and receive from any insurer or any other party any and all documentation and records that I am empowered to request regarding this claim, including, without limitation, a statement of coverage, policy declarations page and insurance policy pursuant to Section 627.4137. In addition, the provider has the authority to request and receive any Independent Medical Examination Reports, notices sent to me regarding appointments for Independent Medical Examinations and Examinations Under Oath (including proof of mail), Records Review Reports, coverage denial letters, Explanations of Benefits, and Benefit Payment Sheets or Logs (P.I.P. Payout Sheets), without regard as to whether such documentation has already been provided to me and,
(2) to endorse in my name any check issued for payment where benefits were assigned. By way of this assignment and notice, I further instruct you, the insurer, to furnish to Provider copies of all future notices affecting Provider's interest in this claim, including, without limitation, any notices of requested medical examinations or statements.

The Provider hereby objects to any reductions or partial payments. Any partial or reduced payment, regardless of the accompanying language, issued by the insurer and deposited by the provider shall be done so under protest, at the risk of the insurer, and the deposit *shall not* be deemed a waiver, *accord, satisfaction*, discharge, settlement or agreement by the provider to accept a reduced amount as payment in full.

I further direct my insurer to direct all payments for services rendered by the Provider directly to Provider at the billing address contained on Provider's medical bills.

THIS IS A DIRECT AND IRREVOCABLE ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER MY POLICY OF INSURANCE.

A photocopy of this form shall be considered as effective and valid as the original.

I have read the foregoing and understand and agree to each of the above provisions:

_____ _____

Patient/Guardian signature Date

FRALICKER CHIROPRACTIC CLINIC **INJURY HISTORY**

PATIENT NAME: _____ TODAY'S DATE: _____

VEHICLE ACCIDENT_____ WORK ACCIDENT_____ OTHER_____

BEFORE TODAY, HAVE YOU EVER BEEN EXAMINED OR TREATED AT OUR OFFICE?_____
IF YES, APPROXIMATELY WHEN WAS YOUR LAST VISIT?_____

IF OTHER THAN AUTO COLLISION, PLEASE DESCRIBE_____

SLIP/FALL_____ LIFTING INJURY_____

DATE OF ACCIDENT/INJURY_____ LOCATION_____

CIRCLE IF YOU WERE THE: DRIVER PASSENGER PEDESTRIAN

IN THE: FRONT SEAT REAR SEAT WERE YOU IN A: CAR TRUCK

WAS ANYONE ELSE IN THE CAR WITH YOU?_____ IF SO, HOW MANY_____

WERE YOU: STOPPED AND REAR ENDED_____ HIT HEAD ON_____
HIT FROM PASSENGER'S SIDE_____ HIT FROM THE DRIVER'S SIDE_____
HIT BY A CAR_____ HIT BY OTHER THAN A CAR_____

PLEASE
DESCRIBE_____

DOLLAR DAMAGE DONE TO YOUR VEHICLE: $_____

WERE YOU WEARING A SEAT BELT? YES____ NO____ WAS IT A SURPRISE COLLISION: YES____ NO____

ON IMPACT, WHICH WAY WAS YOUR HEAD TURNED? RIGHT_____ LEFT_____ AHEAD_____

DID YOU STRIKE ANY OBJECTS INSIDE THE CAR?_____ IF YES, WRITE DOWN **THE PORTION OF YOUR BODY** THAT YOU STRUCK NEXT TO THE OBJECT BELOW:

_____STEERING WHEEL	_____REAR-VIEW MIRROR
_____DASH BOARD	_____HEADREST
_____SIDE WINDOW RT LT	_____WINDSHIELD
_____SIDE DOOR RT LT	_____CONSOLE
_____CANNOT REMEMBER DETAILS	_____OTHER

WERE YOU: DAZED_____ UNCONSCIOUS_____ CUTS (WHERE)_____

BRUISED (WHERE)_____

WAS THERE: MOMENTARY DEAFNESS_____ LOSS OF BALANCE_____ NAUSEA_____
RINGING IN EARS_____ BLURRED VISION_____ IMMEDIATE PAIN_____ DIZZINESS_____

WRITE IN THE BRACKETS ON THE NEXT PAGE APPROXIMATELY WHEN THE PAIN BEGAN AND ALSO THE LOCATION. NOTE IF IT WAS IMMEDIATE PAIN OR LATER:

PAIN BEGAN WHEN?		RIGHT	LEFT	FRONT	BACK
_____	HEADACHES	_____	_____	_____	_____
_____	NECK PAIN	_____	_____	_____	_____
_____	MID-BACK PAIN	_____	_____	_____	_____
_____	LOW-BACK PAIN	_____	_____	_____	_____
_____	ARM PAIN	_____	_____	_____	_____
_____	LEG PAIN	_____	_____	_____	_____
_____	OTHER	_____	_____	_____	_____

IF YOU WERE TAKEN TO THE HOSPITAL IMMEDIATELY, HOW DID YOU GET THERE? (CIRCLE):
AMBULANCE DROVE YOURSELF FRIEND/RELATIVE OTHER_____
IF YOU WENT HOME AND LATER WENT TO THE HOSPITAL, WHEN?_____

NAME OF THE HOSPITAL_____

WERE YOU SEEN IN THE EMERGENCY ROOM?_____ WERE YOU ADMITTED?_____
IF ADMITTED, DATE OF DISCHARGE_____ ADMITTING DOCTOR_____

CIRCLE BELOW THE PROCEDURES DONE IN THE EMERGENCY DEPARTMENT/HOSPITAL:
EXAMINATION STITCHES X-RAYS COLLAR BRACE OTHER_____
WAS FOLLOW-UP CARE ADVISED?_____ IF SO, WITH WHOM?_____
WERE YOU GIVEN A DRUG PRESCRIPTION?_____ DID YOU TAKE IT ALL?_____

AFTER YOU WERE RELEASED FROM THE HOSPITAL, WHAT DID YOU DO?
RETURN TO WORK_____ GO HOME_____ OTHER_____

WHAT DATE DID YOU FIRST CONSULT A PHYSICIAN FOR TREATMENT?_____

FAMILY PHYSICIAN_____ ORTHOPEDIST_____CHIROPRACTOR_____ OTHER_____

PHYSICIAN'S NAME_____

WHAT DID HE SAY WAS WRONG?_____
ARE YOU STILL UNDER DR'S CARE?_____ IF NO, DATE OF LAST VISIT_____

INITIALLY, HOW MANY TIMES PER WEEK WERE YOU TREATED?_____
PRESENTLY, HOW OFTEN ARE YOU TREATED?_____

NAME AND DATE OF LAST DR. SEEN_____

HAS YOUR TREATING DR. AT THIS TIME EXPLAINED TO YOU THE LENGTH OF ADDITIONAL CARE PLANNED FOR YOU?_____ IF YES, PLEASE EXPLAIN_____

_____

TYPE OF TREATMENT RECEIVED:

_____MANIPULATION	_____EXAMINATION	_____X-RAYS
_____MASSAGE	_____ULTRASOUND	_____HOME EXERCISE
_____TRACTION (CERVICAL)	_____HEAT/ICE	_____HOME TRACTION
_____EMS (ELECT PADS)	_____DIATHERMY	_____COLLAR/BRACE
_____OTHER (PLEASE EXPLAIN)_____	_____TENS UNIT	_____WHIRLPOOL

HAVE YOU HAD ANY OTHER ACCIDENTS OR INJURIES AFTER THE DATE OF THIS ACCIDENT:
YES_____NO_____IF YES, PLEASE EXPLAIN_____

LIST ALL PHYSICIANS SEEN AS A RESULT OF THIS ACCIDENT:
CHIROPRACTOR FOR CONSULTATION_____ X-RAYS_____ EXAM_____ OTHER_____

NAME_____ WHEN_____

NEUROLOGIST FOR CONSULTATION_____ X-RAYS_____ EXAM_____ OTHER_____

NAME_____ WHEN_____

ORTHOPAEDIST FOR CONSULTATION_____ X-RAYS_____ EXAM_____ OTHER_____

NAME_____ WHEN_____

FAMILY DOCTOR FOR CONSULTATION_____X-RAYS_____ EXAM_____ OTHER_____

NAME_____ WHEN_____

OTHER PHYSICIAN_____ SPECIALTY_____
WHEN_____FOR_____

ANY SPECIAL TEST PERFORMED? (CIRCLE) YES OR NO IF YES, INDICATE BELOW:
_____MRI: (TO WHAT AREA)_____ DATE DONE:_____
REQUESTED BY_____RESULTS_____

_____NERVE STUDIES: (CIRCLE) SSEP NCV NEEDLE EMG EEG
(TO WHAT AREA)_____ DATE DONE:_____

_____BONE SCAN: (TO WHAT AREA)_____ DATE DONE:_____
REQUESTED BY_____RESULTS_____
_____SPINAL ULTRASOUND STUDIES: (TO WHAT AREA)_____ DATE:_____
REQUESTED BY:_____RESULTS_____

THERMOGRAPHY: (TO WHAT AREA)_____DATE DONE:_____
REQUESTED BY:_____RESULTS_____

_____ DOPPLER _____MYELOGRAM _____MUSCLE STRENGTH TESTING _____MOTION X-RAYS
(TO WHAT AREA)_____DATE DONE:_____
REQUESTED BY:_____RESULTS_____

OTHER TESTING PERFORMED:_____DATE DONE:_____

IS YOUR RECOVERY (CIRCLE ONE) **AT A STAND STILL STILL IMPROVING SAME**
MUCH IMPROVED WORSE

WHAT TIME IN YOUR RECOVERY DO YOU FEEL THAT YOU REACHED A POINT WHERE NO FURTHER IMPROVEMENT WAS NOTICED?_____

DO YOU FEEL WORSE: (CIRCLE) SITTING LYING DOWN MORNING MIDDAY
EVENING AFTER REST AFTER ACTIVITY OTHER_____

DO YOU FEEL BETTER: (CIRCLE) SITTING LYING DOWN MORNING MIDDAY EVENING AFTER REST AFTER ACTIVITY OTHER_____

WHAT ACTIVITIES OR FUNCTIONS ARE YOU **UNABLE** TO PERFORM NOW THAT YOU COULD PERFORM BEFORE THE INJURY? IF NONE, WRITE NONE BELOW.

_____

WHERE THERE ANY **ACCIDENT/INJURIES** BEFORE THIS ONE? _____ IF YES, EXPLAIN DETAILS INCLUDING DATES AND WHO TREATED YOU AND LENGTH OF THERAPY.

_____

_____

_____

LIST ALL PRIOR TREATMENT **(BEFORE THIS INJURY)** FOR HEADACHES, NECK, BACK, ARM OR LEG PAIN WITH DETAILS INCLUDING DATES, LENGTH OF TREATMENT AND DOCTOR'S NAMES.

_____

_____

_____

PHYSICAL HISTORY: (CIRCLE) SEIZURES WEAKNESS SENSORY LOSS VISUAL OR HEARING LOSS BLADDER OR BOWEL DYSFUNCTION OTHER:_____

SOCIAL HISTORY: CIGARETTES ALCOHOL OTHER:_____

MAJOR OR CHRONIC ILLNESSES: NO_____ YES_____ IF YES, PLEASE EXPLAIN:

_____

ANY SURGERIES: NO_____ YES_____ IF YES, PLESE EXPLAIN WITH DATES AND AREAS

_____

FAMILY HISTORY OF ANY HEREDITARY CONDITIONS? NO_____ YES_____ IF YES, WHAT TYPE?

_____

DO YOU HAVE ANY TYPE OF DISABILITY OR HAVE YOU EVER BEEN GIVEN AN IMPAIRMENT RATING? NO_____ YES_____ IF YES, PLEASE EXPLAIN_____

ARE YOU PRESENTLY TAKING ANY KIND OF MEDICATION? NO_____ YES_____ IF SO PLEASE LIST:

_____

_____

WHAT ARE YOUR PRESENT COMPLAINTS OR SYMPTOMS?_____

_____

DID YOU HAVE ANY OF THE ABOVE SYMPTOMS PRIOR TO THIS INJURY? NO_____ YES_____

IF YES, WHICH ONES_____

_____

TYPE OF WORK AT THE TIME OF THE INJURY:_____

FULL TIME PART TIME EMPLOYER_____

WERE YOU OFF WORK AS A RESULT OF THIS INJURY? NO_____ YES_____
IF SO, HOW LONG_____ WAS THIS BY DOCTORS ORDERS? NO_____ YES_____
IF YES, NAME OF DR._____

ARE YOU PRESENTLY EMPLOYED? NO_____ YES_____ IF YES, (CIRCLE) FULL TIME OR PART TIME

TYPE OF WORK AT THIS TIME_____

EMPLOYER AT THIS TIME_____

WHAT TYPE OF TREATMENT ARE YOU RECEIVING AT THIS TIME?_____
_____ DOCTOR'S NAME_____

NAME OF ATTORNEY REPRESENTING YOU:_____

WRITE DOWN ANY ADDITIONAL COMMENTS:_____

_____

_____

_____

WHO IS YOUR PRIMARY MEDICAL PHYSICIAN?_____

MAY WE INFORM HIM/HER OF YOUR INJURIES, TREATMENT PLAN AND
PROGRESS?_____

THANK YOU FOR BEING AS COMPLETE AND ACCURATE AS POSSIBLE.

PATIENTS SIGNATURE:_____ DATE: _____

THE HISTORY WAS TAKEN AND REVIEWED WITH THE PATIENT BY THE PHYSICIAN(S) BELOW:

_____ _____

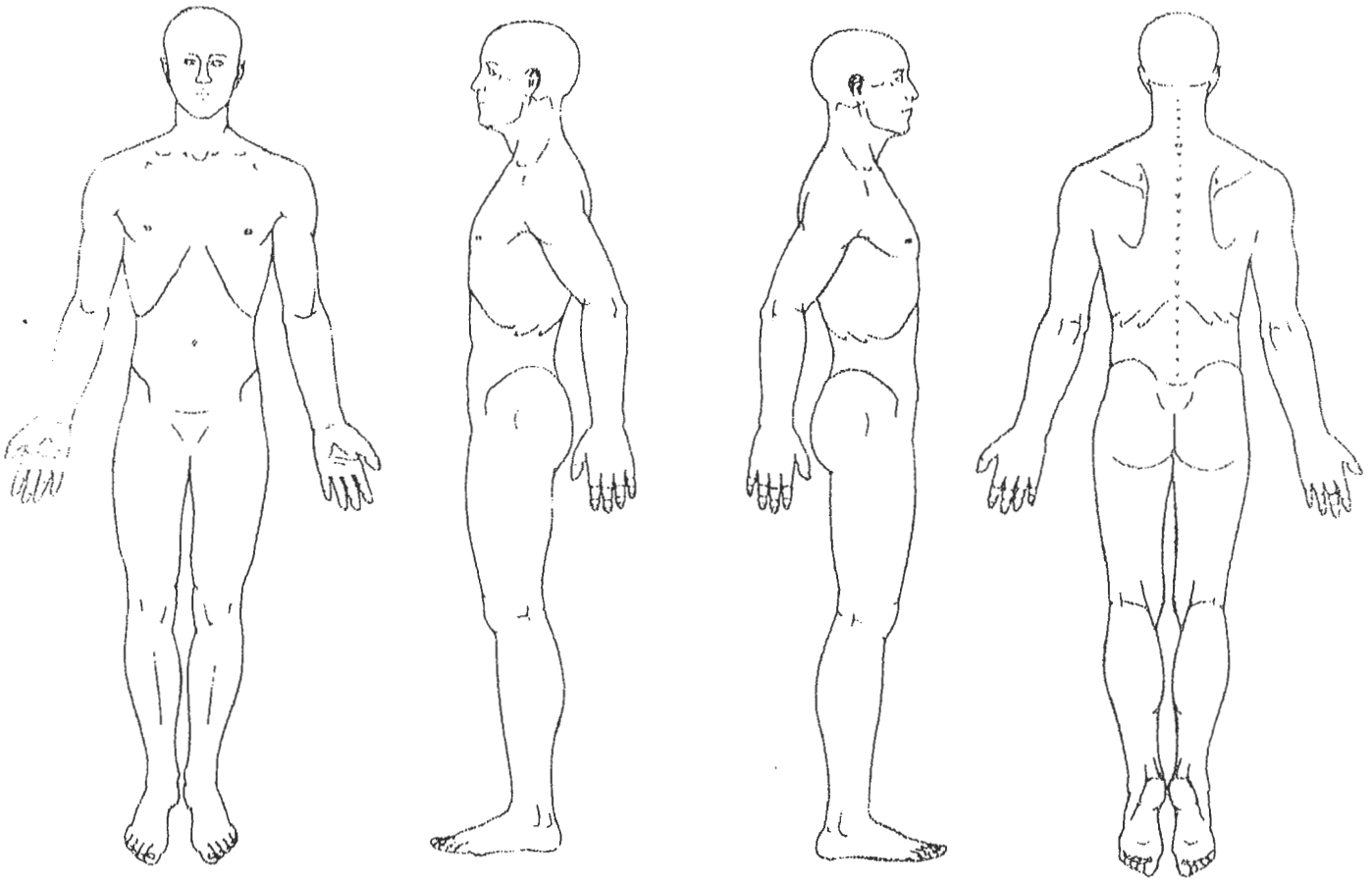
JANN ALLEN FRALICKER, DC **DEBORAH FRALICKER, ARNP, DC**

PAIN ASSESSMENT

Name: _____ Date: _____

Please mark or shade the areas of your body where you feel pain on the diagrams below.

Next to each shaded or marked area, please note the intensity of pain, according to scale below.



No Pain	Minimal		Tolerable, but hinders activities		High - 50% of activities impaired		Extreme - most activities impaired		Unbearable
0	1	2	3	4	5	6	7	8	9

FIGURE 17-A

Pain Disability Questionnaire (PDQ)

NAME: _____ DATE: _____

Please read:

This survey asks for your views about how your pain now affects how you function in everyday activities. This information will help you and your doctor know how you feel and how well you are able to do your daily tasks at this time.

Please answer every question by making an "X" along the line to show how much your pain problem has affected you (from having no problems at all to having the most severe problems you can imagine).

BE SURE TO ANSWER *ALL* QUESTIONS.

1. Does your pain interfere with your normal work inside and outside the home?
   ]_____]_____]_____]_____]_____]
   Work normally — Unable to work at all
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
3. Does your pain interfere with your traveling?
   ]_____]_____]_____]_____]_____]
   Travel anywhere I like — Only travel to see doctors
4. Does your pain affect your ability to sit or stand?
   ]_____]_____]_____]_____]_____]
   No problems — Cannot sit/stand at all
5. Does your pain affect your ability to lift overhead, grasp objects, or reach for things?
   ]_____]_____]_____]_____]_____]
   No problems — Cannot do at all
6. Does your pain affect your ability to lift objects off the floor, bend, stoop, or squat?
   ]_____]_____]_____]_____]_____]
   No problems — Cannot do at all
7. Does your pain affect your ability to walk or run?
   ]_____]_____]_____]_____]_____]
   No problems — Cannot walk/run at all
8. Has your income declined since your pain began?
   ]_____]_____]_____]_____]_____]
   No decline — Lost all income
9. Do you have to take pain medication every day to control your pain?
   ]_____]_____]_____]_____]_____]
   No medication needed — On pain medication throughout the day
10. Does your pain force you to see doctors much more often than before your pain began?
    ]_____]_____]_____]_____]_____]
    Never see doctors — See doctors weekly
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
12. Does your pain interfere with recreational activities and hobbies that are important to you?
    ]_____]_____]_____]_____]_____]
    Normal activity — No recreation/hobbies at all
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
14. Do you now feel more depressed, tense, or anxious than before your pain began?
    ]_____]_____]_____]_____]_____]
    No depression/tension — Severe depression/tension
15. Are there emotional problems caused by your pain that interfere with your family, social, or work activities?
    ]_____]_____]_____]_____]_____]
    No problems — Severe problems

Reproduced with Permission from: Anagnostis C, Gatchel RJ Mayer TG. The Pain Disability Questionaire. Spine 2004, 29:2290-2302.

APPLICATION FOR FLORIDA "NO FAULT" BENEFITS

NAME OF INSURANCE COMPANY

DATE	OUR POLICY HOLDER	DATE OF ACCIDENT	FILE NUMBER

TO ENABLE US TO DETERMINE IF YOU ARE ENTITLED TO BENEFITS UNDER THE FLORIDA PERSONAL INJURY PROTECTION LAW, PLEASE COMPLETE THIS FORM AND RETURN IT PROMPTLY.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURANCE COMPANY MAKES A STATEMENT OF CLAIM CONTAINING ANY FALSE INCOMPLETE OR MISLEADING INFORMATION, IS GUILTY OF A FELONY OF THE THIRD DEGREE.

YOUR NAME	PHONE NO.	HOME	BUSINESS

YOUR ADDRESS (NO, STREET, CITY OR TOWN, STATE AND ZIP CODE)	DATE OF BIRTH	SOCIAL SECURITY NO.

PERMANENT ADDRESS, IF DIFFERENT	HOW LONG HAVE YOU LIVED IN FLORIDA?

DATE AND TIME OF ACCIDENT	PLACE OF ACCIDENT (STREET, CITY OR TOWN AND STATE)

BRIEF DESCRIPTION OF ACCIDENT AND VEHICLES INVOLVED:

DESCRIBE MOTOR VEHICLE YOU OWN -	DESCRIBE MOTOR VEHICLE OWNED BY ANY MEMBER OF YOUR FAMILY-

AS A RESULT OF THIS ACCIDENT, WERE YOU INJURED? IF YOUR ANSWER IS YES, COMPLETE THE REST OF THIS FORM. IF NO, SIGN HERE AND RETURN THIS FORM TO US.

SIGNATURE: DATE:

DESCRIBE YOUR INJURY

WERE YOU TREATED BY A DOCTOR?		DOCTOR'S NAME AND ADDRESS
IF YOU WERE TREATED IN A HOSPITAL, WERE YOU AN IN PATIENT ___ OUT PATIENT ___		HOSPITAL'S NAME AND ADDRESS
AMOUNT OF MEDICAL BILLS TO DATE	WILL YOU HAVE MORE MEDICAL EXPENSE?	AT THE TIME OF YOUR ACCIDENT, WERE YOU IN THE COURSE OF YOUR EMPLOYMENT?
DID YOU LOSE WAGES OR SALARY AS A RESULT OF YOUR INJURY?	IF YES, AMOUNT OF LOSS TO DATE	WHAT IS YOUR AVERAGE WEEKLY WAGE OR SALARY?
IF YOU LOST WAGES:	DATE DISABILITY FROM WORK BEGAN	DATE YOU RETURNED TO WORK
HAVE YOU RECEIVED, OR ARE YOU ELIGIBLE FOR, PAYMENTS UNDER ANY WORKMEN'S COMPENSATION OR EMPLOYMENT LAW?		IF YES, AMOUNT PER WEEK PER MONTH

LIST NAMES AND ADDRESSES OF YOUR PRESENT EMPLOYER(S) AND GIVE YOUR OCCUPATION AND DATES OF EMPLOYMENT FOR EACH

EMPLOYER AND ADDRESS	YOUR OCCUPATION	FROM	TO
EMPLOYER AND ADDRESS	YOUR OCCUPATION	FROM	TO
EMPLOYER AND ADDRESS	YOUR OCCUPATION	FROM	TO

AS A RESULT OF YOUR INJURY HAVE YOU HAD ANY OTHER EXPENSES?	IF YES, EXPLAIN ON REVERSE SIDE
SIGNATURE: DATE:	

IMPORTANT: 1. TO BE ELIGIBLE FOR BENEFITS COMPLETE AND SIGN THIS APPLICATION
2. SIGN AND ATTACH AUTHORIZATION(S)
3. RETURN PROMPTLY WITH ANY MEDICAL BILLS YOU HAVE RECEIVED TO DATE

AUTHORIZATION FOR MEDICAL INFORMATION

THIS AUTHORIZATION OR PHOTOCOPY HEREOF, WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY CONDITION WHILE UNDER YOUR OBSERVATION OR TREATMENT, INCLUDING THE HISTORY OBTAINED, PHYSICAL AND X-RAY FINDINGS, DIAGNOSIS AND PROGNOSIS. YOU ARE AUTHORIZED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE FLORIDA "NO FAULT" AUTO INSURANCE LAW.

_____ _____

Signature Date

AUTHORIZATION FOR WAGE AND SALARY INFORMATION

THIS AUTHORIZATION OR PHOTOCOPY HEREOF, WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY WAGES OR SALARY WHILE EMPLOYED BY YOU. YOU ARE AUTHORIZED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE FLORIDA "NO FAULT" AUTO INSURANCE LAW.

_____ _____

Signature Date

FRALICKER CHIROPRACTIC CLINIC, INC.

LETTER OF PROTECTION
DIRECTION TO PAY

PATIENT: _____

DATE OF BIRTH: _____

DATE OF INJURY: _____

IMPORTANT: THIS IS A CONTRACT. IF YOU DON'T UNDERSTAND THIS THEN CONSULT WITH AN ATTORNEY BEFORE SIGNING.

Patient authorizes and irrevocably directs his/her present and any future attorneys related to the above-referenced date of injury ("Attorneys") to honor this agreement. This irrevocable agreement is made in favor of the above-referenced Medical Provider and shall be termed a "Letter of Protection." The Letter of Protection shall serve to place a continuing lien on any proceeds I recover in any legal action related to the above-referenced date of injury. The Direction to Pay applies to the Patient's Attorneys.

Background. Medical Provider expects to be paid from any proceeds related to the above-referenced date of injury in exchange for providing medical care/treatment. Medical Provider also agrees not to place patient in collections until the resolution of Patient's claims related to the above-referenced date of injury. Patient expects to receive medical care that is reasonable, related to the above-referenced accident and medically necessary. Patient has sustained injuries as a result of injuries related to the above-referenced date of injury and does not have the funds to pay for the medical care which he/she needs. Patient is signing this Letter of Protection in order to receive medical care.

Insurance Benefits. In the event that there are disability benefits, medical payment benefits, No-Fault benefits, health and accidental benefits, worker's compensation benefits, or any other insurance benefits available to Patient besides Bodily Injury and/or Un-insured Motorist (aka Underinsured Motorist) coverage then this Letter of Protection can be used to cover any co-payments and/or deductibles.

Protection of Medical Bills. If Patient recovers any money related to the above-referenced date of injury then Patient's Attorney shall withhold from those funds, sufficient money pay the outstanding balance of any bill(s) owed to Medical Provider. It is understood that Attorney's fees/costs are first-in-line and that this Letter of Protection does not interfere with Attorney's retainer agreement with Patient. Patient authorizes Medical Provider to provide Attorney with a copy of Patient's medical records, bills, etc. with regard to the above-referenced date of injury.

Patient's Responsibility for Bills. Patient understands that he/she is directly responsible to Medical Provider for services rendered and that payment is not contingent on any settlement, judgment, or verdict related to the above-referenced date of injury. Regardless of any settlement, judgment, or verdict, Patient is still responsible for paying Medical Provider's outstanding bills so long as they are reasonable and related to the above-referenced date of injury and medically necessary.

Patient's Responsibility Regarding His/Her Attorney (Present and Future). Patient is responsible for informing each and every attorney retained by him/her of the existence of this agreement. Medical Provider has the right to notify Patient's Attorney(s) about the existence of this Letter of Protection. Upon request, Patient and Patient's Attorney shall provide status updates about any claims related to the above-referenced date of injury as well as the contact information for any new Attorneys. It is also the Patient's responsibility to advise the Medical Provider at least 10 days prior to collecting any funds and to request a bill for any and all outstanding charges. Patient understands that if funds related to the above-referenced date of injury are insufficient to cover the medical bill(s) then Medical Provider has the right to collect the remaining balance.

Disputes. If the Patient fails to pay the Medical Provider's full outstanding balance and Medical Provider is the prevailing party in an action to enforce this Letter of Protection then Medical Provider shall have the right to recover all attorney fees and costs including post-judgment proceedings. Binding arbitration is an option if both parties agree in writing.

Direction to Pay. ATTENTION ATTORNEY: THIS IS AN IRRECOVABLE DIRECTION TO PAY MY MEDICAL PROVIDER. Patient irrevocably directs his/her Attorneys to pay any outstanding medical bills in connection with the above-referenced date of injury. Patient hereby directs Attorneys to provide a status update in writing within 15 days of receiving a request from Medical Provider.

Effective Date. This agreement becomes effective when the Patient signs the agreement below.

Patient Signature	Date
Attorney Signature	Date

Fralicker Chiropractic Clinic, Inc
835 Cesery Blvd
Jacksonville, FL 32211

AUTHORIZATION TO PROVIDE INSURANCE
INFORMATION AND DOCUMENTS

I hereby authorize any insurance company which may provide me with coverage of medical bills incurred as a result of my motor vehicle accident of _____ (date) to provide any and all declaration pages, PIP logs, payout ledgers, explanation of benefits, copies of checks, and any and all other documents or information to Fralicker Chiropractic Clinic, Inc., or any attorney, employee or other representative of their office. I further direct and authorize you to speak to the attorney or employee or any other representative of Fralicker Chiropractic Clinic, Inc., or anyone acting on their behalf over the phone and provide them with any and all information you may have or documentation not previously listed above that they may request. You are authorized to accept a photocopy of this as if it were the original.

_____ _____
Patient Signature Date

_____
Patient's Name (printed)

_____
Patient's Social Security #

_____
Patient's Date of Birth

Fralicker Chiropractic Clinic
835 Cesery Blvd.
Jacksonville, FL 32211

Protecting Your Health Information

New Regulation Passed

The new regulations are part of the Health Insurance Portability and Accountability Act or HIPPA does three primary things:

1. It helps standardize and simplify the way healthcare organizations exchange health care data.
2. It provides consumers with additional protections for getting and maintaining health insurance coverage; although, it does not guarantee coverage.
3. It creates new security rules to ensure the safety and privacy of individual and medical records.

Our Pledge Regarding Medical Information

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our office. We need this record to provide you with quality care and to comply with certain legal requirements. In addition, we have a policy in effect that makes e very attempt to maintain the confidentiality of all patients' information.

Disclosure of Medical Information

In addition to disclosing your medical information for treatment, payment, and health care operations, we may disclose medical information for the following purposes: for a court order, subpoena, discovery request, or other lawful process. We may disclose medical information to appropriate authorities if we reasonably believe that you are a victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose health information when authorized and necessary to comply with laws relating to worker's compensation, auto accidents, personal injury or other similar issues.

If someone calls or comes by, they will be given general about your care and/or appointments unless otherwise specified and noted in your file.

We will also be publicly noting your name in our newsletter and/or picture in our lobby unless otherwise specified. Also upon becoming a patient, we will be entering your name into our database and you will receive our monthly newsletter. If you do not wish to receive our newsletters, please contact our office and advise the receptionist of such. This list will not be sold to any outside agencies.

Your Rights

You have the right to look at or get copies of your medical records and to receive a list of all the times we shared your medical information for purposes other than treatment, payment and health care operations.

Open Adjusting Concept

Because of the open adjusting concept in this office, it is possible for doctor/patient discussions to be overheard by other patients. Most discussions will involve spinal health, but may also include anything concerning the primary health care of that patient.

Notification by Mail or Phone

Patients may be contacted by mail or phone unless written notification is requested that contact be only in person.

Complaints

If you feel that your rights have been violated, contact the Office Manager or the U.S. Department of Health and Human Services.

ACKNOWLEDGMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

_____ _____

Patient Name (please print) Date

_____

Parent, Guardian or Patient's legal representative

_____

Signature

THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS.

Fralicker Chiropractic Clinic

835 Cesery Blvd.
Jacksonville, FL 32211

Terms of Acceptance

The goal of our office is to enable patients to gain control of their health. To attain this we believe communication is the key. There are often topics that are hard to understand and we hope this document will clarify those issues for you.

Please read the below and if you have any question please feel free to ask one of our staff members.

Informed Consent:

A patient, in coming to the chiropractic physician, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or care if he is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through healthcare procedures whatever he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the chiropractic physician. The chiropractic physician provides a specialized, non-duplicating health care service. Your doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regimen. I understand that if I am accepted as a patient by a physician at Fralicker Chiropractic Clinic, I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

Communications:

In the event that we would need to communicate your healthcare information, to who may be do so?

Spouse: _____

Children: _____

Others: _____

May we leave messages on any answering device, i.e. home answering machines or voicemails? Yes [ ] No [ ]

I, _____, have read and fully understand the above statements.

Acknowledgement

I have been given the opportunity to view the notice of privacy practices (HIPPA) and have been provided an opportunity to discuss my right to privacy.

Print Name: _____

Signature: _____ Date: _____

Fralicker Chiropractic Clinic, Inc
835 Cesery Blvd
Jacksonville, FL 32211
Ph. (904)745-1444
Fax (904)743-0805

Records Release Form

I hereby authorize and direct you to release to:

Fralicker Chiropractic Clinic, Inc.

The complete medical records (including all E.R. records and all radiology reports) and X-rays in your possession concerning my illness and/or treatment during the period from _____ to _____.

Emergency Room YES NO

(Patient is to complete the section below)

Print Name: _____

Address: _____

Date of Birth: _____ Social Security: _____

I understand that this records release is effective for one year from the date indicated below.

Signature: _____ Date: _____

Witness: _____

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as a cervical arterial dissection that involves an abnormal change in the wall of an artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. This occurs in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke. As chiropractic can involve manually and/or mechanically adjusting the cervical spine, it has been reported that chiropractic care may be a risk for developing this type of stroke. The association with stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name:_____ Signature:_____ Date:_____

Witness Name:_____ Signature:_____ Date:_____