DOCTOR______

CASH PATIENT INFORMATION

REFERRED BY: ______________________________

PATIENT'S NAME: ______________________ DRIVERS LIC. #: __________
ADDRESS: ______________________ SOCIAL SECURITY #: ______________
CITY: ____________ STATE: ____ ZIP CODE: ______ DATE OF BIRTH: __________
PHONE #: (   ) ____________ EMAIL: ______________________
MALE: ____ FEMALE: ____ MARITAL STATUS: M, S, D, W, SEP
DATE OF INJURY: ______________ INJURED AREA (S): ________________

EMPLOYER: ____________________ OCCUPATION: ________________
ADDRESS: __________________ CITY: ____________ STATE: _____ ZIP: _______
WORK PHONE #: (   ) __________________ HOW LONG: ______________

PRIMARY INSURANCE: __________________ PHONE (   ) ______________
ADDRESS: ____________________ CITY: ____________ STATE: ___ZIP: ______
INSURED'S NAME: ____________________ RELATIONSHIP: ______________
GROUP/POLICY#: ________________ PRIMARY PHYSICIAN: ______________

SECONDARY INSURANCE: __________________ PHONE (   ) ____________
ADDRESS: ____________________ CITY: ____________ STATE: ___ZIP: _______
INSURED'S NAME: ____________________ RELATIONSHIP: ______________
GROUP/POLICY#: ____________________

Were you injured on the job? **Yes** **No**
Were you injured in an Auto Accident? **Yes** **No**

DATE: ______________ SIGNATURE: ______________________________

STADIUM CHIROPRACTIC
& SPORTS MEDICINE REHABILITATION
1940 W. ORANGEWOOD AVE. SUITE 101 ORANGE, CA 92868
PHONE (714) 385-9088 FAX (714) 385-9083

FINANCIAL AGREEMENT
CASH PAYMENT

We would like to take a moment to welcome you to our office and to assure you will be receiving the very best care available for your condition. To familiarize you with the financial policy of our office, I would like to explain how your medical bills will be handled.

PAYMENT ARRANGEMENTS:
It is our policy in this office to maintain your account on a current basis. Charges for treatment are due at the time the service is provided. We ask that you make payments on a visit basis. Your balance must be pain in full on or before the end of the day services are rendered, and any unpaid balance will be considered past due and an interest charge of ________% per month may be applied.

If this arrangement becomes inconvinient for you, please see our office manager so that other arrangements can be made

VOLUNTARY TERMINATION OF CARE:
It is also the policy of this office that if you should choose to suspend or terminate your care and treatment, any outstanding fees for professional services rendered to you will be immediately due and payable.
We hope that this has answered any questions you might have regarding your financial arrangements. Once again, we'd like to welcome you to our office. If at any time, you have questions about your care, please don't hesitate to ask.

I have read and agree to the above.

______________________________ ______________________

Patient Signature: Date:

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 California 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 the California Medical Injury Compensation Reform Act shall apply to disputes within this arbitration agreement, including, but not limited to, sections establishing the right to introduce evidence of any amount payable as a benefit to the patient as allowed by law (Civil Code 3333.1), the limitation on recovery for non-economic losses (Civil Code 3333.2), and the right to have a judgment for future damages conformed to periodic payments (CCP 667.7). 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.

(Date)

PATIENT SIGNATURE **X**

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

(Date)

OFFICE SIGNATURE **X**

ALSO **SIGN** THE **INFORMED CONSENT** ON **REVERSE** SIDE

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 I 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. I 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

NOTICE OF PERSONAL CHIROPRACTOR OR PERSONAL ACUPUNCTURIST

If your employer or your employer's insurer does not have a Medical Provider Network, you may be able to change your treating physician to your personal chiropractor or acupuncturist following a work-related injury or illness. In order to be eligible to make this change, you must give your employer the name and business address of a personal chiropractor or acupuncturist in writing prior to the injury or illness. Your claims administrator generally has the right to select your treating physician within the first 30 days after your employer knows of your injury or illness. After your claims administrator has initiated your treatment with another doctor during this period, you may then, upon request, have your treatment transferred to your personal chiropractor or acupuncturist.

You may use this form to notify your employer of your personal chiropractor or acupuncturist.

Your Chiropractor or Acupuncturist's Information:

____

(name of chiropractor or acupuncturist)

____

(street address, city, state, zip code)

____

(telephone number)

Employee Name **(please print)**:

____

Employee's address:

____

Employee's
Signature____________________________________ Date:______________

Stadium Chiropractic & Sports Medicine Rehabilitation
1940 W. Orangewood, Ste. 101., Orange CA 92868
(714) 385-9088 / fax (714) 385-9083

www.StadiumChiropractic.com

Massage Plan Cancellation Policy

Thank you for taking advantage of the professional massage therapy services offered at Stadium Chiropractic and Sports Medicine Rehabilitation. The following details the office policy as it applies to our massage therapy program:

Cancellations:

- 24 hour notice is required for canceling all scheduled massage therapy sessions.
- All late cancellations will be subject to a cancellation fee of 50% of the massage fee.
- NO SHOWS will be billed 100% of the massage fee.
- Any patient more than 10 minutes late will be considered a NO SHOW *or* may have their scheduled massage time reduced appropriately.
- Our massage therapists appreciate your positive comments. However, tipping and/or the exchange of money in treatment rooms are strictly prohibited.

I have received a copy of these guidelines.

____

Patient Signature Date

Patient Copy / Patient File