

PERSONAL INJURY PATIENT INFORMATION

REFERRED BY: _____ DATE _____

PATIENT'S NAME: _____ DRIVERS LIC #: _____ SEX: M F
ADDRESS: _____ SS# _____ DOB _____
CITY: _____ STATE: _____ ZIPCODE _____
PHONE#: _____ MARITAL STATUS: M S D W SEP
EMAIL: _____ OCCUPATION: _____

PRIMARY HEALTH INSURANCE COMPANY: _____

ADDRESS: _____ PHONE: () _____
CITY: _____ STATE: _____ ZIP: _____
INSURED NAME: _____ RELATIONSHIP: _____ POLICY/ ID#: _____

AUTO INSURANCE COMPANY: _____

ADDRESS: _____ PHONE: () _____
CITY: _____ STATE: _____ ZIP: _____
INSURED NAME: _____ RELATIONSHIP: _____ CLAIM #: _____
MEDPAY: YES: _____ NO: _____ MEDPAY LIMIT: \$ _____

THIRD PARTY INSURANCE COMPANY: _____

ADDRESS: _____ PHONE: () _____
CITY: _____ STATE: _____ ZIP: _____
INSURED NAME: _____ RELATIONSHIP: _____ POLICY/ ID#: _____

ATTORNEY'S NAME: _____

ADDRESS: _____ PHONE: () _____
CITY: _____ STATE: _____ ZIP: _____ FAX: () _____

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

STADIUM

CHIROPRACTIC
SPORTS MEDICINE • REHABILITATION
WORKPLACE INJURIES • PERSONAL INJURIES



April Lopez, D.C.

AUTO ACCIDENT HISTORY FORM

Patient: _____ Date: _____

Where Were You Seated: Driver
 Passenger: Front Back Left Right Middle

Date of Injury: _____ Your Vehicle Year/Make/Model: _____

Property Damage Estimate \$ _____

Other Vehicle Make/Model: _____

Describe how the accident occurred (please be as detailed as possible): _____

Were you aware the impact was going to occur? No Yes
Did you brace for the impact? No Yes
Did you lose consciousness? No Yes

Were you wearing your seat belt? No Yes – Is there a Lap Belt Shoulder Harness
Did the air bags deploy? No Yes
Did you hit your head? No Yes, on the _____

Was your head rotated to the side at the point of impact? No Yes

Did you hit any part of your body on the interior of the vehicle upon impact? No Yes
Body Part: _____ Struck the _____

Were the police called? No Yes Was a police report made? No Yes
Were the paramedics called? No Yes Were you treated on scene? No Yes

Did you go to a hospital? No Yes: By ambulance Drove self
 Someone else took me

Date: _____ Hospital: _____ City: _____
X-Rays Taken: Yes No Medication Given: _____
Treatment Rendered: _____

Date: _____ First Doctor Seen: _____ City: _____
X-Rays Taken: Yes No Medication Given: _____
Treatment Rendered: _____

Date: _____ Second Doctor Seen: _____ City: _____
X-Rays Taken: Yes No Medication Given: _____
Treatment Rendered: _____

AUTOMOBILE ACCIDENT HISTORY FORM – Page 2

PATIENT SECTION – Please Complete The Following Information

Patient: _____

CURRENT COMPLAINTS:

Body Part: _____

How often do you have this pain? Occasional (25% of time) Intermittent (50% of time)
 Frequent (75% of time) Constant (100% of time)

How bad is this pain on a scale from 0-10? (see scale below)

No Pain: 0—1—2—3—4—5—6—7—8—9—10: Excruciating Pain

Where does this pain radiate to? _____

What activities make this pain worse? _____

Body Part: _____

How often do you have this pain? Occasional (25% of time) Intermittent (50% of time)
 Frequent (75% of time) Constant (100% of time)

How bad is this pain on a scale from 0-10? (see scale below)

No Pain: 0—1—2—3—4—5—6—7—8—9—10: Excruciating Pain

Where does this pain radiate to? _____

What activities make this pain worse? _____

Body Part: _____

How often do you have this pain? Occasional (25% of time) Intermittent (50% of time)
 Frequent (75% of time) Constant (100% of time)

How bad is this pain on a scale from 0-10? (see scale below)

No Pain: 0—1—2—3—4—5—6—7—8—9—10: Excruciating Pain

Where does this pain radiate to? _____

What activities make this pain worse? _____

Please list any additional pain or symptoms you are experiencing as a result of this accident:

PLEASE USE THE BACK OF THIS SHEET TO PROVIDE ADDITIONAL INFORMATION.

AUTOMOBILE ACCIDENT HISTORY FORM – Page 3

PATIENT SECTION – Please Complete The Following Information

Patient: _____

Please check any of the following symptoms you have experienced since the accident occurred:

General Complaints:

- | | |
|--|---|
| <input type="checkbox"/> Ringing/Buzzing in ears | <input type="checkbox"/> Cold hands / feet |
| <input type="checkbox"/> Loss of: balance / memory | <input type="checkbox"/> Diarrhea / upset stomach |
| <input type="checkbox"/> Loss of: smell / taste | <input type="checkbox"/> Visual Disturbances |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Tension |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Lights bother eyes |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Cold sweats |
| <input type="checkbox"/> Pain behind eyes | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Loss of sleep | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> High stress levels | |
| <input type="checkbox"/> TMJ | <input type="checkbox"/> Burns: _____ |
| <input type="checkbox"/> Bruises: _____ | <input type="checkbox"/> Lacerations: _____ |
- Other Complaints: _____

Past Medical History:

Prior Injuries:

Prior Trauma/Accident/Injuries: _____
Prior Automobile Accidents: _____
Prior Work Injuries: _____

General Health History: Check all condition you current have.

- | | | |
|---------------------------------------|---------------------------------------|---|
| <input type="checkbox"/> Diabetic | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Chronic Depression |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Stroke | <input type="checkbox"/> Anxiety / Panic Attacks |
| <input type="checkbox"/> Neck Surgery | <input type="checkbox"/> Back Surgery | <input type="checkbox"/> Heart Attack / Cardiac Condition |
| <input type="checkbox"/> _____ | <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |

Other: _____

Prior Surgical History:

Date: _____ Procedure: _____
Date: _____ Procedure: _____
Date: _____ Procedure: _____

Medical History:

What medications are you currently taking for the symptoms relating to your accident?

What other medications are you taking for any other condition unrelated to this accident?

List any allergies to medication you have: _____

PLEASE USE THE BACK OF THIS SHEET TO PROVIDE ADDITIONAL INFORMATION.
AUTOMOBILE ACCIDENT HISTORY FORM – Page 4

PATIENT SECTION – Please Complete The Following Information

Patient: _____

Social History:

Your Age: _____ Are you: Single Married Separated Divorced

How many children do you have? _____ Do you smoke? No Yes

Please list any hobbies you have:

WORK HISTORY:

Employer at the time of the Injury: _____

Occupation: _____

Have you missed time from work as a result of this accident? : No Yes

If yes, please list the dates you missed from work: _____

Describe your job duties in detail: _____

Have you had any pain while performing your job duties that you did not have prior to this accident? No Yes

DUTIES UNDER DURESS:

Describe how the accident has affected your lifestyle:

With performing your work activities (pain with sitting, standing, bending, pushing, pulling, etc):

With performing domestic duties (laundry, dishes, vacuuming, cleaning, preparing meals, etc):

While participating in sports activities (running, amateur/professional athlete, etc.):

While vacationing or traveling (business or pleasure, cancelled travel plans, unable to sit, etc.):

PLEASE USE THE BACK OF THIS SHEET TO PROVIDE ADDITIONAL INFORMATION.

PATIENT SECTION – Please Complete The Following Information

ACTICITIES OF DAILY LIVING:

Please describe your ability perform the following daily living activities and qualities of life. If you have any problems performing any of them, please be as descriptive as possible in order to help determine how the injuries resulting from the accident have affected you.

Self Care – Hygiene:

- | | | |
|---|--|----------------------------------|
| <input type="checkbox"/> brushing teeth | <input type="checkbox"/> combing / fixing hair | <input type="checkbox"/> bathing |
| <input type="checkbox"/> dressing | <input type="checkbox"/> putting on socks or shoes | |

Other: _____

Communication:

- | | | |
|---|---|--|
| <input type="checkbox"/> problems with speech | <input type="checkbox"/> memory / concentration | <input type="checkbox"/> visual disturbances |
| <input type="checkbox"/> hearing | <input type="checkbox"/> TMJ – jaw popping | |

Other: _____

Limitation of Activity:

- | | | | | |
|--|----------------------------------|-----------------------------------|----------------------------------|----------------------------------|
| <input type="checkbox"/> sleeping | <input type="checkbox"/> sitting | <input type="checkbox"/> standing | <input type="checkbox"/> walking | <input type="checkbox"/> running |
| <input type="checkbox"/> going up or down stairs | | | | |

Other: _____

Sensory:

- | | |
|--|--|
| <input type="checkbox"/> problems with touch | <input type="checkbox"/> loss of sensation in the: _____ |
| <input type="checkbox"/> smell | <input type="checkbox"/> taste <input type="checkbox"/> balance and coordination |

Reduced Hand Function:

- | | | |
|--|--|------------------------------------|
| <input type="checkbox"/> finger motion | <input type="checkbox"/> hand control or motion | <input type="checkbox"/> weak grip |
| <input type="checkbox"/> dropping things | <input type="checkbox"/> tingling or numbness in hands | |

Other: _____

Travel:

- | | | | |
|---|---------------------------------|----------------------------------|----------------------------------|
| <input type="checkbox"/> duration of travel | <input type="checkbox"/> riding | <input type="checkbox"/> driving | <input type="checkbox"/> walking |
| <input type="checkbox"/> rough ground | <input type="checkbox"/> flying | | |

Other: _____

Sexual:

Are you having any difficulties or pain with sex? No Yes
 If yes, please explain: _____

Sleep Deprivation:

- | | | |
|---|--|--|
| <input type="checkbox"/> interruption frequency | <input type="checkbox"/> interruption pain | <input type="checkbox"/> morning fatigue |
| <input type="checkbox"/> irritability | <input type="checkbox"/> reduced daytime alertness | <input type="checkbox"/> forgetfulness |
| <input type="checkbox"/> tension | <input type="checkbox"/> anxiety | <input type="checkbox"/> depression |
| <input type="checkbox"/> panic attacks | <input type="checkbox"/> shortness of breath | <input type="checkbox"/> nightmares |

Other: _____

PLEASE USE THE BACK OF THIS SHEET TO PROVIDE ADDITIONAL INFORMATION.

STADUM CHIROPRACTIC & REHABILITATION CENTER

DOCTORS LIEN

ATTORNEY:

TREATING DOCTOR:

April A. Lopez, D.C.
1940 W. Orangewood Ave Suite 101
Orange, CA 92868
(714)385-9088 Fax: (714)385-9083

RE: Agreement and Lien in Reference to Patient: _____

This Agreement and Lien is entered into between above mention Attorney, Doctor and patients in consideration of the mutual obligations set forth herein, and to make certain their responsibilities to each other during the pendency of Patients Claim for damages arising from an accident/injury which occurred on: _____.

Patient hereby authorizes Doctor to provide Attorney with complete reports of Patient's medical condition, care and cost of treatment.

Patient hereby gives a Lien to Doctor against all proceeds derived from this claim (Whether by settlement, judgment, or otherwise) to secure payment for services owed to Doctor by Patient at the time said proceeds are received. Patient hereby directs Attorney to honor said Lien and to pay such sums that are secured thereby directly to Doctor as soon as possible after any proceeds are received, Patient further gives a lien to said Doctor against all proceeds of any settlement, judgement, or verdict which may be paid to you, my attorney, or myself as a result of the injuries for which I have been treated in connection therewith. It is agreed that Attorney shall disclose to and receive acceptance from Doctor is to receive on this Claim, otherwise, this Lien shall remain in effect.

Patient hereby expressly recognizes that even though this Lien has been granted, Patient remains personally responsible for Doctor's fees and that payment of said fees must be made by Patient even in the event that no monies are recovered through this claim. This lien supersedes any and all payment contracts or notes, including that of all coverage's, insurance agreements or automobile medical payment policies, regardless of any reductions, discounts or other limitations placed upon the Doctor's billing or the Patients responsibility for payment contained therein.

Patient and Attorney hereby agree to notify Doctor immediately should Patient retain new legal counsel. Also, Attorney agrees to give written notice of this Agreement and Lien to the new Attorney and patients agrees to execute another copy of this Agreement and Lien when one is furnished by Doctor.

In witness of these mutual obligations and responsibilities, the Doctor/Patient/Attorney Agreement and Lien is agreed to and entered into.

Patient Signature

Date

Attorney 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

"It is our practice to participate in charitable events to raise awareness, food donations, gifts, money, etc. During these times, we may send you a letter, post card, invitation or call your home to invite you to participate in the charitable activity. We will provide you with information about the type of activity, the dates and times, and request your participation in such an event. It is not our policy to disclose any personal health information about your condition for the purpose of Stadium Chiropractic & Sports Rehabilitation sponsored fund-raising events."

Change of Ownership.

In the event that Stadium Chiropractic & Sports Rehabilitation is sold or merged with another organization, your health information/record will become the property of the new owner.

Your Health Information Rights

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that Stadium Chiropractic & Sports Rehabilitation is not required to agree to the restriction that you requested.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- You have the right to inspect and copy your health information.
- You have a right to request that Stadium Chiropractic & Sports Rehabilitation amend your protected health information. Please be advised, however, that Stadium Chiropractic & Sports Rehabilitation is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.

➤ You have a right to receive an accounting of disclosures of your protected health information made by Stadium Chiropractic & Sports Rehabilitation.

➤ You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to this Notice of Privacy Practices

Stadium Chiropractic & Sports Rehabilitation reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, Stadium Chiropractic & Sports Rehabilitation is required by law to comply with this Notice.

Stadium Chiropractic & Sports Rehabilitation is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact privacy officer Zulma Gutierrez or the additional appointed person(s) by calling this office at 714-385-9088. If the privacy officer / additional appointed person(s) is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

Complaints

Complaints about your Privacy rights, or how Stadium Chiropractic & Sports Rehabilitation has handled your health information should be directed to the privacy officer / additional appointed person(s) by calling this office at 714-385-9088. If the privacy officer / additional appointed person(s) is not available, you may make an appointment for a

personal conference in person or by telephone within 2 working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

This notice is effective as of October 1, 2003.

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide Stadium Chiropractic & Sports Rehabilitation with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice

Patient's Name (print)

Patient's Signature

Date

personal conference in person or by telephone within 2 working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

This notice is effective as of October 1, 2003.

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide Stadium Chiropractic & Sports Rehabilitation with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice

Patient's Name (print)

Patient's Signature

Date

> You have a right to receive an accounting of disclosures of your protected health information made by Stadium Chiropractic & Sports Rehabilitation.

> You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to this Notice of Privacy Practices

Stadium Chiropractic & Sports Rehabilitation reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, Stadium Chiropractic & Sports Rehabilitation is required by law to comply with this Notice.

Stadium Chiropractic & Sports Rehabilitation is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact privacy officer Zulma Gutierrez or the additional appointed person(s) by calling this office at 714-385-9088. If the privacy officer / additional appointed person(s) is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

Complaints

Complaints about your Privacy rights, or how Stadium Chiropractic & Sports Rehabilitation has handled your health information should be directed to the privacy officer / additional appointed person(s) by calling this office at 714-385-9088. If the privacy officer / additional appointed person(s) is not available, you may make an appointment for a

FORM 03-501

"It is our practice to participate in charitable events to raise awareness, food donations, gifts, money, etc. During these times, we may send you a letter, post card, invitation or call your home to invite you to participate in the charitable activity. We will provide you with information about the type of activity, the dates and times, and request your participation in such an event. It is not our policy to disclose any personal health information about your condition for the purpose of Stadium Chiropractic & Sports Rehabilitation sponsored fund-raising events."

Change of Ownership.

In the event that Stadium Chiropractic & Sports Rehabilitation is sold or merged with another organization, your health information/record will become the property of the new owner.

Your Health Information Rights

> You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that Stadium Chiropractic & Sports Rehabilitation is not required to agree to the restriction that you requested.

> You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.

> You have the right to inspect and copy your health information.

> You have a right to request that Stadium Chiropractic & Sports Rehabilitation amend your protected health information. Please be advised, however, that Stadium Chiropractic & Sports Rehabilitation is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.



Dr. April A. Lopez
1940 W. Oranewood Ave Ste. 101
Orange, CA. 92868
Phone: 714-385-9088
Fax: 714-385-9083
Email: DrAprilLopez@StadiumChiropractic.com

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize _____ to
release healthcare information of the patient named above to:

Name: STADIUM CHIROPRACTIC SPORTS MEDICINE AND REHABILITATION CENTER

Address: 1940 W. ORANGEWOOD AVE STE. 101

City: ORANGE State: CA Zip Code: 92868

This request and authorization applies to:

Healthcare information relating to the following treatment, condition,
diagnosis or dates: _____

- X-Ray History Reports Billings
 All healthcare information

Other: _____

Patient Signature: _____ Date Signed: _____

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: _____

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