DOCTOR__________

INDUSTRIAL PATIENT INFORMATION

REFERRED BY: ________________________________ **TODAY'S DATE:** ______________

FIRST NAME: __________________ M.I.______ LAST: __________________________ SEX: M F
SOCIAL SECURITY #: ____________________DRIVERS LIC. #: ______________________
ADDRESS: ___________________________ CITY: _______________ STATE: ____ ZIP: _______
DATE OF BIRTH: _________________ PHONE #: (   ) ___________________
EMAIL:____________________________________ MARITAL STATUS: M, S, D, W, SEP.

OCCUPATION:____
EMPLOYER: ____
ADDRESS: ____________________________ CITY: _____________ STATE: ______ ZIP ______
EMPLOYER PHONE #: (   ) ____________________ FAX #: ______________________

ATTORNEY'S NAME: ____________________________ PHONE# (   ) __________________
ADDRESS: ______________________________________ FAX #: (   ) __________________
CITY, STATE, ZIP: __________________________ CONTACT NAME: ________________

DATE OF INJURY: ___/___/___ TIME OF INJURY: _________ DATE LAST WORKED: __/__/__
DESCRIBE ACCIDENT: ____
____
____

OFFICE USE ONLY

INDUSTRIAL INSURANCE CARRIER: ____
ADDRESS: ______________________________ CITY, STATE, ZIP: _______________________
PHONE#: (   )__________________________ FAX#: (   )____________________________
CLAIMS ADJUSTER: ________________________________ **CLAIM#:** ___________________
EMPLOYER: ____
DATE OF INJURY: ____/____/_____ INJURED AREA: ___________________________
PTP: _________________ PTP PHONE #: ____________________ FAX:___________________

COMMENTS

____
____
____

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

FINANCIAL AGREEMENT
WORKERS' COMPENSATION

We would like to take a moment to welcome you to our office and to assure you that you will be receiving the very best care available to you for your work-related injury or illness.

Payment Arrangements

Because you are being treated for a work-related condition, we would like for you to understand how your case will be handled by our office. The first thing that you need to know is that your employer or your employer's insurance carrier, by law, is financially responsible for payment of all treatment charges which are a result of your industrial injury or condition. You are entitled to receive to all necessary care and treatment which restores your health to a pre-injury status or to a permanent and stationary condition.

Notification of Employer

When you have suffered a work-related injury or illness, the law requires that you notify your employer immediately, no later than 30 days from knowledge of your injury. If you do not report your injury as required, you may lose your benefits and you may be responsible to personally pay for the charges incurred in our office.

Pre-existing Condition or Symptoms

If it has been determined, upon my evaluation, that you are currently experiencing symptoms or problems that are unrelated to your industrial injury, your employer's Workers' Compensation insurance carrier will not be responsible for treatment to your unrelated condition. We will be happy to file a separate claim to your private or group health insurance policy, if appropriate.

Your Responsibilities

This office specializes in the treatment of Workers' Compensation patients, so it is very important for you to follow our recommendations and to keep your scheduled appointments with this office in order to achieve maximum benefit to your condition. If you choose not to receive the care that is necessary for treatment of your condition, the workers' compensation insurance carrier will discontinue your benefits and your case will be closed.

Termination of Care

When your condition has reached a "pre-injury status," or is determined to be "permanent and stationary", we will notify you and your Workers' Compensation insurance carrier, and close your Workers' Compensation claim in our office.

We thank you for the opportunity to serve you and welcome any questions that you may have concerning your case.

I have read and agree to the above.

Patient's Signature ______________________ Date ______________

EMPLOYER NOTICE OF CHANGE OF PHYSICIAN
(California Code of Regulations Section 9783)

EMPLOYER: ______________________________ DATE: ______________

INSURANCE CARRIER: ______________________ CLAIM #: ______________

EMPLOYEE: ______________________________ DATE OF INJURY: __________

Pursuant to California code of Regulations, Section 9783, the designated period of employer medical control has passed from the date on which I reported my work-related injury. This letter serves to notify you, my employer, and/or their Worker's Compensation insurance company, that I am changing my treating physician from:

DR. __________________________ to DR. April A. Lopez, D.C.

1940 W. Orangewood Avenue Suite 101, Orange, CA 92868 — 714-385-9088
(address) — (telephone)

My signature below also authorizes Dr. April A. Lopez, D.C. to release necessary information regarding my condition to you, my employer and/or their worker's compensation insurance company, to process this claim.

According to California Labor Code Section 4600-4600.3, after the designated period of employer medical control has passed, the employee may be treated by a physician of his or her own choice. And, according to CCR Section 9783, the employee shall immediately notify the employer/insurer of the address of the physician selected.

Signed: __________________________ Date: ________________

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:

Dr. April A. Lopez

(name of chiropractor or acupuncturist)

1940 W. Orangewood Ave Suite 101 Orange, CA 92868

(street address, city, state, zip code)

(714)385-9088 Fax: (714) 385-9083

(telephone number)

Employee Name **(please print)**:

____

Employee's address:

____

Employee's Signature______________________________ Date:______________

DWC FORM 9783.1 (March 14, 2006)

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

STADIUM CHIROPRACTIC & SPORTS REHABILITATION

NOTICE OF PRIVACY PRACTICES

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

Stadium Chiropractic & Sports Rehabilitation is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of Your Health Care Information

Treatment
We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations. (example)

"On occasion, it may be necessary to seek consultation regarding your condition from other health care providers associated with Stadium Chiropractic & Sports Rehabilitation."

"It is our policy to provide a substitute health care provider, authorized by Stadium Chiropractic & Sports Rehabilitation to provide assessment and/or treatment to our patients, without advanced notice, in the event of your primary health care provider's absence due to vacation, sickness, or other emergency situation."

Payment
We may disclose your health information to your insurance provider for the purpose of payment or health care operations. (example)

"As a courtesy to our patients, we will submit an itemized billing statement to your insurance carrier for the purpose of payment to Stadium Chiropractic & Sports Rehabilitation for health care services rendered. If you pay for your health care services personally, we will, as a courtesy, provide an itemized billing to your insurance carrier for the purpose of reimbursement to you. The billing statement contains medical information, including diagnosis, date of injury or condition, and codes which describe the health care services received."

Workers' Compensation
We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

Emergencies
We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

Public Health
As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

Judicial and Administrative Proceedings.
We may disclose your health information in the course of any administrative or judicial proceeding.

Law Enforcement.
We may disclose your health information to law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

Deceased Persons.
We may disclose your health information to coroners or medical examiners.

Organ Donation.
We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

Research.
We may disclose your health information to researchers conducting research that has been approved b[illegible]n Institutional Review Board.

Public Safety.
It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

Specialized Government Agencies.
We may disclose your health information for military, national security, prisoner and government benefits purposes.

Marketing.
We may contact you for marketing purposes or fundraising purposes, as described below: (example)

"As a courtesy to our patients, it is our policy to call your home on the evening prior to your scheduled appointment or after a missed appointment to remind you of your appointment time or to re-schedule. If you are not at home, we leave a reminder message on your answering machine or with the person answering the phone. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment."

"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 disclosed 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

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