1. Patient Information

Date_____

Patient Name_____

Address_____

City_____State_____Zip_____

E-mail_____

Sex □ M □ F Age_____

Birthdate_____

Marital Status_____

Number of Children_____

Driver's License Number_____

Occupation_____

2. Phone Numbers

Cell Phone(_____)_____

Home Phone(_____)_____

Best place to reach you_____

IN CASE OF EMERGENCY, CONTACT

Name_____

Relationship_____

Phone Number_____

3. Insurance Information

Name of person responsible for your payment_____

Insurance Co._____

Policy #_____ Group #_____

Subscriber's Name_____ Relationship to Patient_____ Date of Birth_____

ASSIGNMENT & RELEASE

I irrevocably assign Countryside Chiropractic to the extent of any services rendered to me by Countryside Chiropractic the proceeds of any settlement or judgment resulting from the exercise by myself of myself of any rights of recovery I have against any person or organization legally responsible for the bodily injury for which I have been rendered treatment and/or all rights and benefits of any insurance policy under which such services are covered.

I further authorize and direct you: (a) my insurance company is potentially liable to me under coverage provisions of an insurance policy I hold with you, (b) an insurance company which is potentially liable to me by virtue of the acts of its insured, and/or (c) my attorney, to pay Countryside Chiropractic directly, from any insurance benefits for which you are obligated to reimburse me, or from any settlement, judgment or verdict which I may receive against you, or my attorney may receive on my behalf.

I agree that Countryside Chiropractic be given Power of Attorney to endorse, sign my name on any and all checks for payments of my doctor's bill. I also authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney involved in this case. A photocopy of this Assignment shall be considered as effective and valid as the original.

This assignment is made in consideration of Countryside Chiropractic awaiting payment for services rendered. I understand that this no way relieves me of my primary personal obligation to pay for such services that the signing of this form does not prohibit customary billing by you. I understand that I will be liable for any balance, which remains unpaid after application of any payment under this assignment.

Date_____ Signature of Patient_____

Witness_____ Signature of Policy Holder (if other than patient)_____

4. Medical Information

Present Complaint

Please check any of the following that apply

- ☐ Headache
- ☐ Head seems too heavy
- ☐ Head & shoulders tired & heavy
- ☐ Mental dullness
- ☐ Loss of memory
- ☐ Equilibrium problems
- ☐ Dizziness
- ☐ Fainting
- ☐ Tremors
- ☐ Palpitation
- ☐ Neck pain
- ☐ Neck stiffness
- ☐ Neck motion restricted
- ☐ Upper back pain/stiffness
- ☐ Mid back pain/stiffness
- ☐ Low back pain/stiffness

Difficulty in excessive

- ☐ Standing
- ☐ Walking
- ☐ Riding
- ☐ Bending

Pain radiating into

- ☐ Right Arm
- ☐ Right Leg
- ☐ Both
- ☐ Left Leg
- ☐ Left Arm
- ☐ Both

Difficulty in excessive

- ☐ Lifting
- ☐ Light
- ☐ Moderate
- ☐ Heavy
- ☐ Repetitive

Pain radiating into

- ☐ Neck
- ☐ Base of skull
- ☐ Shoulder
- ☐ Arms
- ☐ Hips
- ☐ Legs

Pins & needles in

- ☐ Arms
- ☐ Legs

Numbness in

- ☐ Fingers
- ☐ Arms
- ☐ Legs

- ☐ Chest pain
- ☐ Shortness of breath
- ☐ Eye strain
- ☐ Pain behind eyes
- ☐ Eyes sensitive to light
- ☐ Loss of focus
- ☐ Double vision
- ☐ Ears buzzing/ringing
- ☐ Loss of taste
- ☐ Loss of smell
- ☐ Sinus trouble
- ☐ Extreme nervousness
- ☐ Tension
- ☐ Irritability
- ☐ Anxiety
- ☐ Extreme Fatigue
- ☐ Insomnia
- ☐ Neuritis
- ☐ Face flushed
- ☐ Face Pale
- ☐ Excessive perspiration
- ☐ Digestive disorders
- ☐ Nausea, vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Depression
- ☐ Swollen
- ☐ Feet/hands cold
- ☐ Difficulty in prolonged car riding

Symptoms other than above _____

_____

Did you require post-accident hospitalization? ☐ Yes ☐ No If so, where? _____

Have you had similar accidents or injuries before? ☐ Yes ☐ No

5. Past Medical History

If any of the following are relevant to your medical history, please check below

Myself	Other Family Member	
☐	☐	Cancer
☐	☐	Polio
☐	☐	Tuberculosis
☐	☐	High Blood Pressure
☐	☐	Heart Trouble
☐	☐	Diabetes
☐	☐	Hepatitis
☐	☐	German Measles
☐	☐	Venereal Disease

Myself	Other Family Member	
☐	☐	Muscular Dystrophy
☐	☐	Multiple Sclerosis
☐	☐	Convulsions
☐	☐	Epilepsy
☐	☐	Concussion
☐	☐	Dizziness
☐	☐	Arthritis
☐	☐	Neuritis
☐	☐	Rheumatism

Myself	Other Family Member	
☐	☐	Rheumatic Fever
☐	☐	Scarlet Fever
☐	☐	Nervousness
☐	☐	Asthma
☐	☐	Digestive Disorders
☐	☐	Sinus Trouble
☐	☐	Backaches
☐	☐	Numbness
☐	☐	Anemia

Describe any operations you have had _____

When? _____

Have you been treated by a physician for any health condition in the past year? _____Yes _____ No

If so, describe the condition _____

Date of last physical exam _____

Are you allergic to any medication? _____Yes _____ No. If yes, what kind? _____

Are you currently taking any medication? _____Yes _____ No If yes, what kind? _____

Are you pregnant? _____Yes _____ No Date of last menstrual period _____

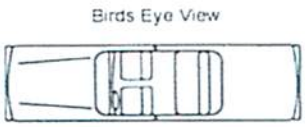
Patient's Name _____ Date _____

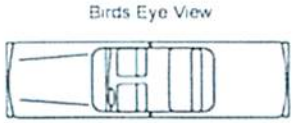
1. Auto Accident Diagram

Show us (x) where you were struck.

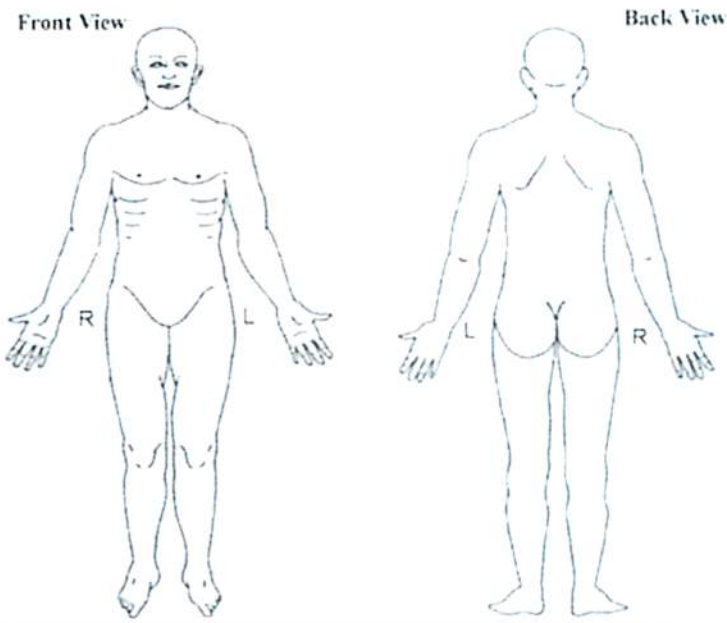
Your car.

Other car.





2. Show us where it hurts



Please mark area(s) of injury or discomfort using the appropriate symbols.

X Numbness
O Pins & needles
● Burning
✓ Aching
> Stabbing

Signature_____ Date _____

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 an 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: _____

Parent or Guardian: _____ Signature: _____ Date: _____

Witness Name: _____ Signature: _____ Date: _____

ALSO **SIGN** THE **ARBITRATION AGREEMENT** ON **REVERSE** SIDE

PATIENT NAME:

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to 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 state 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 state and federal law, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non-economic losses, and the right to have a judgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. 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.

Patient Name: _____ Signature: _____ Date: _____

Parent or Guardian: _____ Signature: _____ Date: _____

Witness Name: _____ Signature: _____ Date: _____

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

COUNTRYSIDE CHIROPRACTIC

GIUSEPPE GIOVATTO JR, DC, CCSP

28467 US HIGHWAY 19 N, SUITE 302

CLEARWATER, FL 33761

O: (727) 216-6929; F: (727) 216-6930

Dear New Patient,

Thank you for choosing our office for your healthcare needs. This disclosure form is meant to make all patients aware of our office policies and procedures. After reviewing, please sign and date this form and we will be happy to provide you a personal copy.

Cancellation & Missed Appointments

As a courtesy to all patients, we request that any cancelled appointments be done so with 24 hours' notice. Any missed appointments without proper notification are subject to a missed appointment charge of $25.00. In addition, arriving 15 minutes or more after your scheduled appointment time will result in cancellation of that appointment and a $25.00 charge.

Please understand that we take great care in ensuring that each patient is given the time and attention needed to address their healthcare concerns. Missed appointments can result in an appointment that another patient would have benefitted from greatly. We appreciate your understanding and assistance in this regard.

Thank you,

Giuseppe Giovatto Jr, DC, CCSP

Please sign and date: _____