ORANGE PARK & ARGYLE CHIROPRACTIC CENTERS

AUTO INJURY QUESTIONNAIRE

Date: _____

Email Address: _____

Last Name: _____ First: _____ Middle: _____

Mailing Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____ Home Phone: _____

Sex: M F DOB: ___/___/___ Marital Status: S M D W

Employed By: _____ Phone: _____

Emergency Contact Name: _____ Phone: _____

HEARD ABOUT OUR OFFICE BY: _____

Is patient here as the result of an accident? Y N **Date of Accident:** ___/___/___

Accident type: AUTO WORK HOME RECREATION SPORTS

Primary Insurance Company: _____

Insured: SELF SPOUSE PARENT/GUARDIAN

Insured's DOB: ___/___/___ Insured's SS#: _____

Insured Employer: _____

Who is your Primary Care Physician? _____

WHAT IS YOUR CURRENT AREA(S) OF COMPLAINT? _____

What surgeries have you had (type and when): _____

_____

List any previous accidents and falls: (Auto, Work, Sports, Home, Other): _____

_____

List any broken bones you may have had: _____

Do you have any drug allergies?

_____

Do you smoke: Y N Alcohol: Y N _____

ASSIGNMENT OF BENEFITS

I, _____, hereby irrevocably assign to Argyle Chiropractic Center, P.A. / Orange Park Chiropractic Center, P.A. any and all benefits and rights I have under any policy of insurance, indemnity agreement, or any other collateral source as defined by the Florida Statutes for any service and/or charges provided by Argyle Chiropractic Center, P.A. / Orange Park Chiropractic Center, P.A.

In witness whereof, the undersigned have hereunto set their hands, this _____ day of _____ of 20____.

_____ X_____

Patient Name Patient Signature

PLEASE CIRCLE ALL CURRENT CONDITIONS

SKIN
Skin Disorder
Shingles
Bruises Easily
Boils
Hives or Allergies

RESPIRATORY
Difficulty Breathing
Chronic Cough
Coughing Phlegm/Blood
Asthma

NERVOUS SYSTEM
Hot/Cold Spots
Numbness/Tingling
Dizziness
Paralysis
Fainting
Convulsions
Irritability
Tremors
Insomnia
Depression
Confusion
Forgetfulness

GENERAL
Fever
Thyroid Disorder
Chills
Diabetes
Sweats
Rheumatic Fever
Chronic Fatigue
Cancer
Loss of Weight
Weight Trouble
HIV
Hepatitis C

GENIO-URINARY
Urine Disorder Frequent
Excessive/Scanty/Painful
Discolored/Blood/Pus
Kidney Infections/Stones
Cancer
Prostatitis
Bladder Trouble

FEMALE
Periods-Painful
Irregular/Cramps
Hot Flashes
Breast-Lumps/Congested
Menopause Symptoms

GASTRO-INTESTINAL
Chronic Nausea
Vomiting
Vomiting Blood
Difficulty Chewing
Swallowing
Excessive Thirst
Gastritis/Heartburn
Pain over Stomach
Ulcers/Stomach Disorders
Distention of Abdomen
Constipation
Diarrhea
Liver Trouble
Gallbladder Trouble

PRIMARY SYMPTOMS
Recurring Headaches
Facial/Jaw Pain
Restricted Movement
Head/Neck
Neck Pain
Neck Spasms
Poor Posture
Upper Back Pain
Sore Aching
"Shawl Muscles"
Pain Shoulder/Arm/Hand
Restricted Movement
Shoulder/Arm/Hand
Swollen Arm/Hand
Arthritis
Pain Beneath/Under
Shoulder Blade
Pain around Collar Bone
Mid Back Pain
Scoliosis
Low Back Pain
Neuritis
Buttock Pain
Hip Pain
Sciatica
Restricted Movement
Leg/Foot
Leg Cramps
Leg Pain/Lower/Upper
Sore Weak Muscles
Walking Problems

CARDIO VASCULAR
Heart Attack
High Blood Pressure
Low Blood Pressure
Rapid Beating Heart
Slow Beating Heart
Pain Over Heart
Hardening Arteries
Swelling of Ankles
Poor Circulation
Stroke
Varicose Veins

EYES/EARS/NOSE AND THROAT
Zig Zag Flashes
Chronic Earache
Hearing Loss
Ear Discharge
Nose Pain
Nose Bleeding
Sore Throat
Hoarseness

I, _____ agree that if I do not give a 24 hour notice I will be responsible to pay the no show fee of $15.00.

Sign _____ Date: _____

Witness _____ Date: _____

PLEASE USE THE FOLLOWING COLORS TO SHOW THE PRESENT AREAS OF COMPLAINTS AND THE TYPES OF PAIN:

BLUE	=	PAIN / ACHE / TENDERNESS
PINK	=	BURNING
GREEN	=	SPASMS / CRAMPING
YELLOW	=	PINS / NEEDLES / NUMBNESS / TINGLING
ORANGE	=	TIGHTNESS / STIFFNESS

Comments: _____

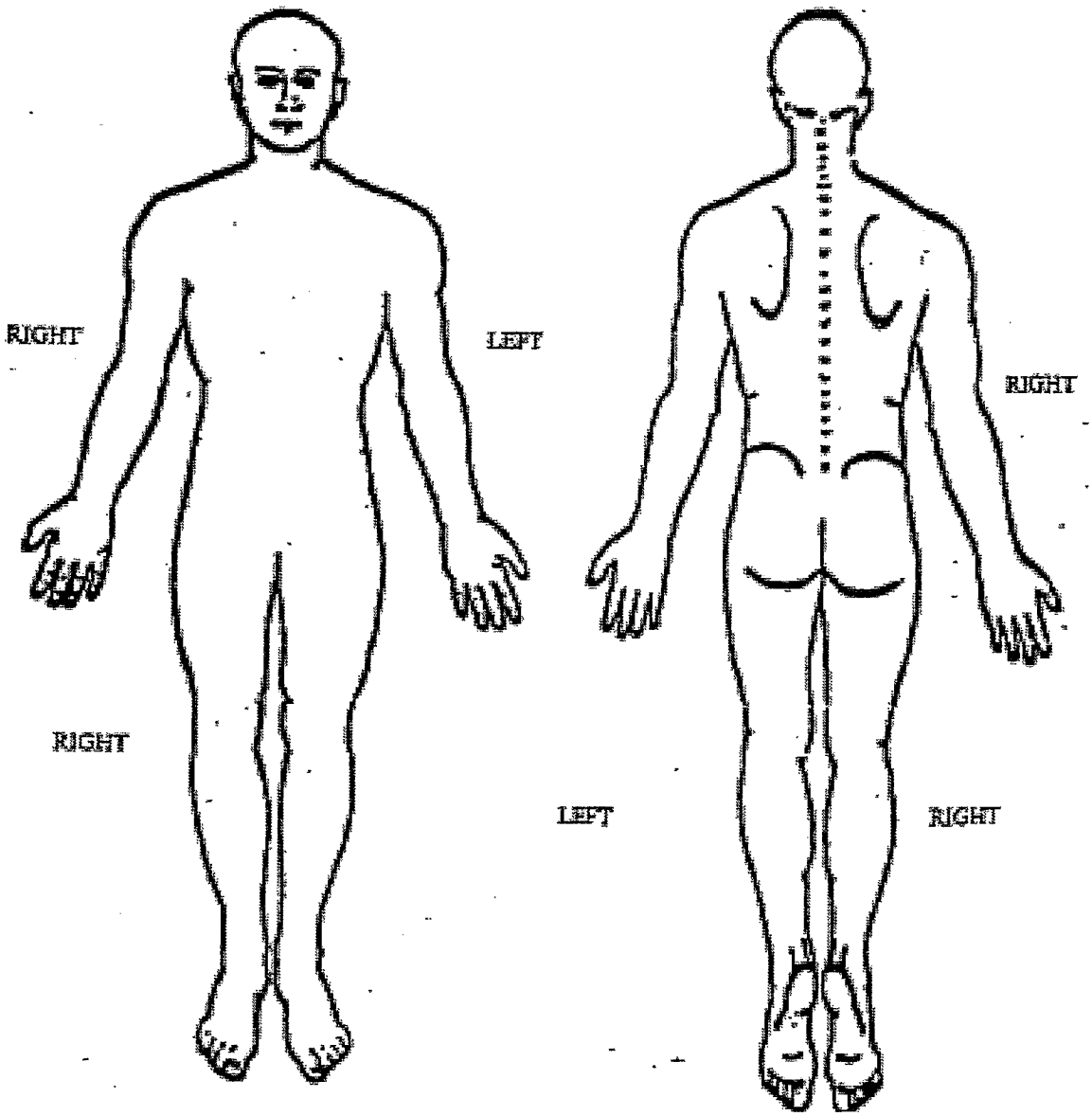
Patient's Signature: _____ Date: _____

Name Printed: _____

Using a scale of 1 – 10, Rate the Intensity of each complaint area:

1 = Least Intensity

10 = Greatest Intensity



FAMILY HISTORY: Review the disease categories and use the appropriate letter (s):

GP (grandparent) F (father) M (mother) H (husband) W (wife) B (brother) S (sister) C (child)

Arthritis _____ Kidney/Liver _____

Asthma _____ Low Back Pain _____

Cancer _____ Mental Illness _____

Depression _____ Migraine _____

Diabetes _____ Multiple Sclerosis _____

Disc Degeneration _____ Polio _____

Emphysema/Lung _____ Scoliosis _____

Epilepsy _____ Sinus Infections _____

Headaches _____ Stomach _____

Heart Attack _____ Thyroid _____

High Blood Pressure _____ Tuberculosis _____

FOR WOMEN ONLY: Are you pregnant? N Y Any Chance? N Y

Use Birth Control? N Y Pills Condoms Shots Diaphragm Tubal Hysterectomy Vasectomy

Date last menstrual period began: _____/_____/_____ Do you have painful periods? N Y

Patient Signature _____ Date _____

AUTHORIZATION TO RELEASE OR RECEIVE MEDICAL INFORMATION
and
AUTHORIZATION OF ASSIGNMENT OF BENEFITS

We strongly feel that all patients deserve from us the very best medical care that we can provide. Further, we feel that everyone benefits when definitive financial arrangements are agreed upon. Accordingly, we have prepared this material to acquaint you with our policy.

Our professional services are rendered to you, not the insurance company. Therefore, payment for treatment is your responsibility.

PLEASE READ AND SIGN THE FOLLOWING:

1) I authorize this office to release or receive any information necessary for my medical file and to expedite insurance claims.
2) I hereby authorize this office to bill my insurance company directly for their services.
3) I authorize payment directly to this physician of any insurance benefits otherwise payment to me.
4) In the event I receive payment from my insurance carrier, I agree to endorse any payment I receive over to my physician for which these fees are payable.

I understand that I am directly and fully financially responsible to this physician for charges not paid by my insurance. I further understand that such payment is not contingent on any settlement, judgment or insurance payment by which I eventually recover that fee. I realize that if my insurance company fails to pay my balance in full, or there is no payment made within 60 days, it is my responsibility to pay my doctor's bill directly. Further, I agree to pay Orange Park Chiropractic Center, P.A. / Argyle Chiropractic Center, P.A. the difference, if any, between the total amount of charges and the amount paid to me by the attorney and/or insurance carrier.

I further understand and agree that if I had to make timely payments on my account, I will be responsible for any and all reasonable costs of collection, including filing fees as well as reasonable attorney's fee.

A photo static copy of these authorizations and agreement shall be as valid as the original.
I understand that if I am accepted as a patient at Orange Park Chiropractic Center, P.A. / Argyle Chiropractic Center, P.A., I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risks associated with chiropractic will be explained upon my request.

Signature _____

Date _____

Witness _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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

_____ _____

Patient Name (please print) Date

_____

Parent, Guardian or Patient's Legal Representative

_____

Signature

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

ORANGE PARK CHIROPRACTIC CENTER
ARGYLE CHIROPRACTIC CENTER
Dr. Keith Schertell

784 Blanding Blvd., Suite 106 Orange Park, FL 32065 (904) 272-4555
6251 Argyle Forest Blvd., Unit 4, Jacksonville, FL 32244 (904) 778-0968

DOCTOR'S LIEN

I hereby authorize Orange Park Chiropractic Center, P.A. / Argyle Chiropractic Center, P.A. hereafter referred to as doctor to furnish you, my attorney, with a full report of the examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was recently involved.

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing for medical service rendered me both by reason of this accident and by reason of any other settlement, judgment, or verdict as may be necessary to adequately protect said doctor. And, I hereby further give a lien on my case to said doctor against any and all proceeds of my settlement, judgment, or verdict which may be paid to you, my attorney, or myself as the result of the injuries for which I have been treated or injuries in connection therewith.

I agree never to rescind this document and that a rescission will not be honored by my attorney. I hereby instruct that in the event another attorney is substituted in this matter, the new attorney honor this lien as inherent to the settlement and enforceable upon the case as if it were executed by the new attorney.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by said doctor for services rendered me and that this agreement is made solely for said doctor's additional protection and in consideration of the doctor's awaiting payment. And, I further understand that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover said fee.

Please acknowledge this letter by signing below and returning to the doctor's office. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment but will require me to pay on my account and keep it on a current basis.

Date_____ Patient's Signature_____

The undersigned being attorney of record for the above patient does hereby agree to observe all terms of the above and agrees to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect said doctor. Attorney further agrees that in the event this lien is litigated that the prevailing party will be awarded attorney fees and costs.

Date_____ Attorney's Signature_____

(A photocopy of this form shall be considered as valid as the original.)

PERSONAL INJURY QUESTIONNAIRE

Auto Insurance Company: _____
Policy: _____ Adjustor: _____
Claim #: _____

Secondary Insurance Company: _____
Policy: _____ Agent: _____

Attorney Name: _____ Phone: _____
Address: _____ City: _____ State: _____ Zip: _____

Were there any witnesses? ( ) Yes ( ) No
If yes, please list: _____

ACCIDENT INFORMATION
Date of accident: _____ Time of day: _____
Were you: ( ) Driver ( ) Passenger ( ) Front Seat ( ) Rear Seat
Number of people in your vehicle: _____ Other vehicle: _____
What direction were you headed? ( ) North ( ) South ( ) East ( ) West
On what street? _____
What direction was the other vehicle headed? ( ) North ( ) South ( ) East ( ) West
On what street? _____
Were you struck from: ( ) Behind ( ) Front ( ) Left Side ( ) Right Side
Were you knocked unconscious? ( ) Yes ( ) No If yes, for how long? _____
Were the police notified? ( ) Yes ( ) No

What was your position in the car?
( ) Driver: if driver were your hands on the steering wheel? ( ) Left ( ) Right ( ) Both
( ) Passenger: if passenger, were you sitting in ( ) Front Seat ( ) Right Rear ( ) Left Rear
Did your vehicle strike another vehicle? ( ) Yes ( ) No
Angles of impact…First collision: ( ) Front ( ) Back ( ) Left ( ) Right
If second collision: ( ) Front ( ) Back ( ) Left ( ) Right
Were you wearing a seat belt? ( ) Yes ( ) No
Did you brace for impact? ( ) Yes ( ) No ( ) I braced with my hands ( ) I braced with my feet
Which way were you facing at the time of impact? ( ) Straight ahead ( ) Left ( ) Right
Did you strike anything in the vehicle during the impact? ( ) Yes ( ) No
If yes, specify what part of your body struck what: (i.e.…head, chest, shoulder, right/left knee)

( ) Steering wheel _____ ( ) Dashboard _____
( ) Windshield _____ ( ) Roof _____
( ) Left Side Door _____ ( ) Right Side Door _____
( ) Left Side Window _____ ( ) Right Window _____
( ) Other _____

Did the seat back bend/break? ( ) Yes ( ) No

In your own words, please describe the accident:

Did you have physical complaints before the accident? ( ) Yes ( ) No
If yes, please describe:

Describe how you felt:
During the accident:
Immediately after the accident:
Later that day:
The next day:

What are your present complaints and symptoms?

Do you have any congenital (from birth) factors that relate to this problem? ( ) Yes ( ) No
If yes, please describe:

Do you have any previous illnesses that relate to this situation? ( ) Yes ( ) No If yes, please describe:

Have you ever been involved in an accident before? ( ) Yes ( ) No If yes, please describe in detail (including injuries):

Where were you taken after the accident?

What physicians treated you after the accident?

What type of treatment did you receive?

Have you sought any medical care since accident? Y___ N___
If yes, where and what form of care/treatment did you receive?

Since this is the most recent accident, are your symptoms: ( ) Improving ( ) Getting worse ( ) Same

Check the symptoms that you have noticed:

( ) Headache	( ) Irritability	( ) Loss of Balance
( ) Neck Pain	( ) Numbness	( ) Fainting
( ) Chest Pain	( ) Shortness of Breath	( ) Loss of Senses
( ) Back Pain	( ) Fatigue	( ) Diarrhea
( ) Dizziness	( ) Depression	( ) Cold in Extremities
( ) Tension	( ) Ears Ring or Buzz	( ) Stomach Upset
( ) Cold Sweats	( ) Sharp Pains	( ) Constipation

Have you lost time at work as a result of this accident? ( ) Yes ( ) No

Last Day Worked: _____

Type of Employment: _____

Do you notice any activity limitations as a result of this injury? ( ) Yes ( ) No

If yes, describe:

_____

_____

Other pertinent information:

_____

_____

PATIENT SIGNATURE: _____ DATE: _____

Activities of Daily Living Assessment

Patient Name: _____ Date: ____/____/____

Directions: This questionnaire has been designed to give the doctor information as to how your pain continues to affect your ability to manage in every day life. Please circle one number in each section which most closely applies to you.

Section I – Pain Intensity

1. The patient can tolerate the pain they have.
2. The pain is bad but the patient can manage without taking pain medication.
3. Pain medication gives complete relief from pain.
4. Pain medication gives moderate relief from pain.
5. Pain medication gives very little relief from pain.
6. Pain medication has no effect on the pain and the patient does not use them.

Section II – Personal Care (Washing, Dressing, Etc.)

1. The patient's personal care does not cause additional pain.
2. The patient can perform personal care normally but it causes additional pain.
3. The patient finds it painful to perform personal care and is slow and careful.
4. The patient needs some help but manages most of the personal care.
5. The patient needs help everyday in most aspects of self care.
6. The patient does not get dressed, washes with difficulty and stays in bed.

Section III – Lifting

1. The patient can lift heavy weights without extra pain.
2. The patient can lift heavy weights but it gives extra pain.
3. Pain prevents the patient from lifting heavy weights off of the floor, but can manage if they are conveniently positioned.
4. Pain prevents the patient from lifting heavy weights but can manage light to medium weights if they are convenient.
5. The patient can lift only very light weight.
6. The patient cannot lift or carry anything at all.

Section IV – Walking

1. Pain does not prevent the patient from walking any distance.
2. Pain prevents the patient from walking more then one (1) mile.
3. Pain prevents the patient from walking more then ½ mile.
4. Pain prevents the patient from walking more then ¼ mile.
5. The patient can only walk using a cane or crutches.
6. The patient is in bed most of the time and has to crawl to the toilet.

Section V – Sitting

1. The patient can sit in any chair for any given length of time.
2. The patient can only sit in their favorite chair for any given length of time.
3. Pain prevents the patient from sitting more then 1 hour.
4. Pain prevents the patient from sitting more then ½ hour.
5. Pain prevents the patient from sitting more then 10 minutes.
6. Pain prevents the patient from sitting at all.

Section VI – Standing

1. The patient can stand for any given length of time without additional pain.
2. The patient can stand for any given length of time but it causes additional pain.
3. Pain prevents the patient from standing more then 2 hours.
4. Pain prevents the patient from standing more then 30 minutes.
5. Pain prevents the patient from standing more then 10 minutes.
6. Pain prevents the patient from standing at all.

Section VII – Sleeping

1. Pain does not prevent the patient from sleeping well.
2. The patient can sleep well but only by using tablets.
3. The patient has less then 6 hours sleep before the pain wakes them.
4. The patient has less then 4 hours sleep before the pain wakes them.
5. The patient has less then 2 hours sleep before the pain wakes them.
6. Pain prevents the patient from sleeping at all.

Section VIII – Sex Life

1. The patient's sex life is normal.
2. The patient's sex life is normal but causes some extra pain.
3. The patient's sex life is nearly normal but is very painful.
4. The patient's sex life is severely restricted by pain.
5. The patient's sex life is nearly absent because of pain.
6. Pain prevents any sexual activity at all.

Section IX – Social Life

1. The patient's social life is normal and causes no extra pain.
2. The patient's social life is normal but increases the degree of pain.
3. Pain has no significant effect on the patient's social life apart from limiting the more energetic interests such as dancing, etc.
4. Pain restricts the patient's social life; therefore the patient can not go out as often.
5. Pain has restricted the patient's social life to home.
6. The patient has no social life because of pain.

Section X – Traveling

1. The patient can travel anywhere without extra pain.
2. The patient can travel anywhere but it causes extra pain.
3. Pain is bad but the patient can manage journeys over 2 hours.
4. Pain restricts the patient to journeys of less then 1 hour.
5. Pain restricts the patient to short necessary journeys less than 30 minutes.
6. Pain prevents the patient from traveling except to the doctor.

Section XI – Menstrual Cycle (WOMEN ONLY)

1. Since the accident my menstrual cycle is normal.
2. Since the accident my menstrual cycle is normal but causes some extra pain.
3. Since the accident my menstrual cycle is nearly normal but is very painful.
4. Since the accident my menstrual cycle is not normal and causes severe pain.
5. Since the accident my menstrual cycle restricts me from performing daily tasks because the pain is so severe.
6. Since the accident I am totally bedridden with my menstrual cycle.

Are there any other activities not listed that you have had to stop doing since the accident?

A) _____ D) _____

B) _____ E) _____

C) _____ F) _____

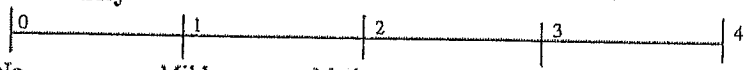
Patient Signature _____ Date: _____

Functional Rating Index

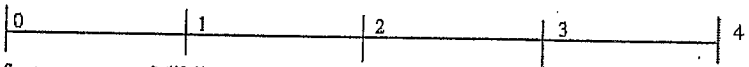
For use with Neck and/or Back Problems only.

In order to properly assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities. For each item below, **please circle the number which most closely describes your condition right now.**

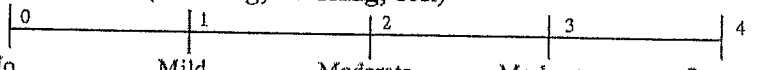
1. Pain Intensity



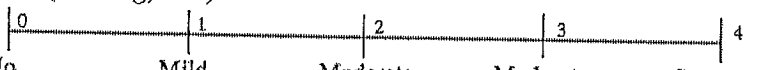
2. Sleeping



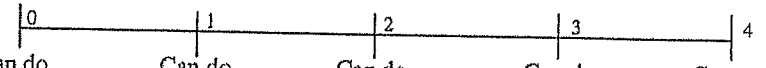
3. Personal Care (washing, dressing, etc.)



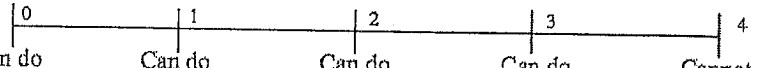
4. Travel (driving, etc.)



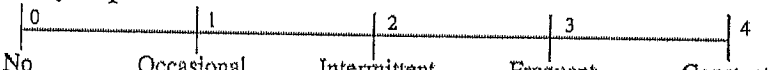
5. Work



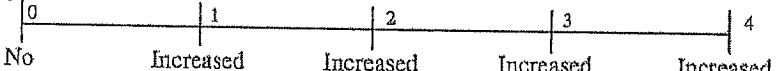
6. Recreation



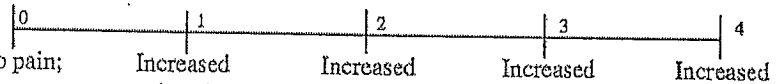
7. Frequency of pain



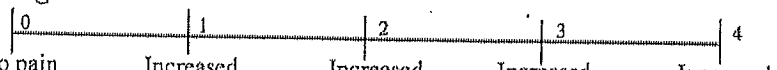
8. Lifting



9. Walking



10. Standing



Name _____
PRINTED

_____
Signature

_____
Date

Total Score _____

~ LOW BACK PAIN AND DISABILITY QUESTIONNAIRE (ROWLAND-MORRIS) ~

When your low back hurts, you may find it difficult to do things that you normally do each day.

CIRCLE ONLY THE SENTENCES THAT DESCRIBE YOU RIGHT NOW!

1. I stay at home most of the time because of my back.
2. I walk more slowly then usual because of my back.
3. Because of my back, I am not doing any jobs that I usually do around the house.
4. Because of my back, I have to use a handrail to go upstairs.
5. Because of my back, I lie down to rest more often.
6. Because of my back, I have to hold onto something to get out of an easy chair.
7. Because of my back, I try to get other people to do things for me.
8. I get dressed more slowly then usual because of my back.
9. I stand up only for short periods of time because of my back.
10. Because of my back, I try not to bend or kneel down.
11. I find it difficult to get out of a chair because of my back.
12. My back or leg is painful almost all of the time.
13. I find it difficult to turn over in bed because of pain in my back.
14. I have trouble putting on my socks or stockings because of my pain.
15. I do not sleep well because of my back.
16. I avoid heavy jobs around the house because of my back.
17. Because of my back pain, I am more irritable and bad tempered with people than usual.
18. Because of my back, I go up stairs more slowly than usual.
19. I change position frequently to try and get my back comfortable.
20. I sit down most of the day because of my back.

Circle your pain level **right now**; place a "B" by the best # you felt today & a "W" by the worst.

0	1	2	3	4	5	6	7	8	9	10

0 = No Pain 10 = Unbearable Pain

Patient Signature _____ Date _____

ASSIGNMENT OF BENEFITS

I, _____, authorize _____
(Patient's name) (Insurance Company name)
to make medical benefits payments otherwise payable to me for services rendered by **ORANGE PARK CHIROPRACTIC CENTER, P.A. / ARGYLE CHIROPRACTIC CENTER, P.A.,** but not to exceed the charges of those services, payable to and mailed directly to:

ORANGE PARK CHIROPRACTIC CENTER, P.A.
784 BLANDING BOULEVARD, SUITE 106
ORANGE PARK, FL 32065

ARGYLE CHIROPRACTIC CENTER, P.A.
6251 ARGYLE FOREST BOULEVARD, UNIT 101
JACKSONVILLE, FL 32244

I hereby instruct the insurance carrier that in the event that the subject medical benefits are disputed and/or reduced for any reason, including medical reasonableness and/or necessity, that the amount of the unpaid benefits claimed by **ORANGE PARK CHIROPRACTIC CENTER, P.A. / ARGYLE CHIROPRACTIC CENTER, P.A.,** is to be set aside and not disbursed until the dispute is resolved.

Furthermore, I hereby IRREVOCABLY ASSIGN TO **ORANGE PARK CHIROPRACTIC CENTER, P.A. / ARGYLE CHIROPRACTIC CENTER, P.A.,.** the rights and benefits and any and all causes of action resulting from any reduction and/or nonpayment under any policy of insurance, indemnity agreement or any other collateral source as defined by Florida Statutes for any service and/or charges provided by **ORANGE PARK CHIROPRACTIC CENTER, P.A. / ARGYLE CHIROPRACTIC CENTER, P.A.**

IN WITNESS WHEREOF, the undersigned have hereunto set their hands, this _____ day of _____, 20_____.

_____ _____
Patient Name Printed Patient Signature

_____
Provider Signature

ORANGE PARK CHIROPRACTIC CENTER
ARGYLE CHIROPRACTIC CENTER

DR. KEITH SCHERTELL

Date

PIP adjuster
Address
City, State, Zip

RE: Patient name
Policy No.
Claim No.
D.O.L:

Dear Sir or Madam:

I am the treating physician and the assignee of the insured, my patient, _____.
I have attached the assignment of benefits as support.
A dispute has arisen regarding the amount of Personal Injury Protection benefits Mr./Ms. _____ is being afforded. Specifically, both myself and Mr. / Ms. _____ is unsure of his/her benefits and he/she is questioning whether or not there will be a patient balance over the 80% PIP coverage amount. In other words, a dispute has arisen as to whether or not you, the PIP carrier, has afforded Mr. / Ms. ___ an Emergency Medical Condition determination to allow him/her the full $10,000.00 in benefits.

Pursuant to Fla. Statute Section 627.736(6)(f), please allow this letter to serve as my request for notification of whether the policy limits have been reached. By law you are required to provide this information to me within 15 days after the limits have been reached.

I look forward to receiving your response within 15 days from receipt of this letter as provided in the new PIP law. Should you fail to provide a response within 15 days, both I and my patient will rely upon your lack of response as indication that the full $10,000.00 in coverage has been afforded and that you are not contesting the Emergency Medical Condition.

Thank you.

Very Truly Yours,

Orange Park Chiropractic Center
784 Blanding Boulevard, Suite 106, Orange Park, Florida 32065
Phone (904) 272-4555 Fax 276-2521

Argyle Chiropractic Center
6251 Argyle Forest Boulevard Unit 101, Jacksonville, Florida 32244
Phone (904) 778-0968 Fax (904) 573-1821

ORANGE PARK CHIROPRACTIC CENTER
ARGYLE CHIROPRACTIC CENTER

DR. KEITH A. SCHERTELL

NEUROMUSCULAR THERAPY NOTICE

I agree that a No-show fee of $15.00 will be assessed for any missed Neuro Muscular Therapy appointments without a 24 hrs cancellation notice.

X_____

What I'm Taking	Reason for Use	Form *(pill, patch, liquid, injection, etc.)*	Dosage	How Much & When	Use *(regularly or occasionally)*	Start/Stop Dates *(1/05/05 – 3/05/05) (1/01/94 – ongoing)*	Notes or Special Directions
*Be sure to include ALL prescription drugs, over-the-counter drugs, vitamins, and herbal supplements.							
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ORANGE PARK AND ARGYLE CHIROPRACTIC CENTERS

LETTER OF PROTECTION

Dear Sir or Madam:

Our office has agreed to provide services for the above named patient, related to the above noted date of accident/injury. "Services" is defined to include supplies. In exchange for not requiring full payment at the time of service, the patient has agreed to execute this letter of protection and we have agreed to accept this letter of protection.

The patient hereby agrees to pay the billing for our services from any recovery obtained by the patient due to the above noted accident. This letter of protection is intended to be a legally enforceable agreement requiring the attorney(s) and/or law firm representing the patient to pay the billing for our services from any recovery obtained for the patient. Accordingly, this letter of protection includes both the signature of the patient and the authorized signatory for the patient's attorney(s), agreeing to pay the billing for our services from any recovery obtained for the patient.

At the time of any recovery on behalf of the patient for the above noted accident, the attorney(s) agree to request in writing the balance due from our office and we agree to respond in writing stating the balance owed for services related to the above noted accident.

The attorneys for the patient agree that any outstanding bill for services owed to us by the patient due to the above noted accident shall be paid directly to us from the amount recovered and collected, if such amount is adequate to cover the bill. The "amount recovered" for the patient shall be defined as the gross sum received, less payment of our attorney's fee and client costs, and also less statutory liens that take priority over this letter of protection.

If the patient objects to the amount of the bill, the attorney(s) agree to hold in their trust account an amount sufficient to pay the entire bill or that portion of the amount recovered that is available to pay the bill, whichever is less. The only exception would be upon an Order of a Court of competent jurisdiction directing the payment of such funds.

(Continued)

If, after a reasonable period, there appears to be no agreement between us and the patient, the attorney(s) will notify both the patient and us that the entire amount held to pay the bill will be deposited with the Clerk of the Court in the County in which the funds are being held in trust and shall be made the subject of an interpleader action.

It is intended the patient's signature on this agreement is an irrevocable letter of protection directing payment of our bill by any subsequent attorney of the patient for the above-noted accident. If the patient obtains a recovery and has no attorney at the time of such recovery, it is intended this agreement by the patient is a direction to any party such recovery to honor this letter of protection. This letter of protection does not eliminate or compromise the obligation of the patient to pay the billing for our services if there is no recovery obtained by the patient.

I have reviewed, understand, and agree to the terms of this letter of protection:

Patient: _____
Date: _____

Attorney(s) for the Patient: _____
Date: _____

Informed Consent for Chiropractic Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may affect the restoration and preservation of health. Health is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an adjustment. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, to include, but not limited to, various modes of physical therapy, diagnostic x-rays and spinal decompression, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while implied by, working, or associated with, or serving as back-up for the chiropractor named below, including those working at the clinic or office listed below or any other office or clinic associated with the following clinic: Orange Park Chiropractic Center/ Argyle Chiropractic Center.

I have had an opportunity to discuss with the doctor of chiropractic named below the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to, 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, and is my best interest. Alternative treatments may include: medication, surgery, or Physical Therapy procedures. As with any of these alternative procedures there are risks. If no treatment is sought, your condition could get worse, remain the same, or improve.

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 form to cover the entire course of treatment for my present condition. Any new condition other than what I am being treated for will be explained to me and a new consent will be signed.

Patient's Signature Date

To be completed by patient's Representative, if patient is a minor or is physically or mentally incapacitated.

Name of Patient

Doctor's Signature Date

Signature of Patient's Representative

Relationship to Patient

ORANGE PARK CHIROPRACTIC CENTER
ARGYLE CHIROPRACTIC CENTER

DR. KEITH SCHERTELL

Policy: NO Show for Scheduled Appointments: Dismissal from practice after 3 No Shows for a scheduled appointment, or when patients fail to show for medically necessary follow up.

Procedure:

1. Call to cancel a scheduled appointment prior to the appointment.

   Patients are expected to keep their scheduled appointment, if a patient needs to cancel their appointment, please call as soon as possible prior to the scheduled time. Cancellations can be taken by calling the office at any time, this includes after business hours. We will call to reschedule during business hours.

2. Appointments for follow up are crucial to good medical care, scheduled appointments must be kept.

3. If a patient NO SHOWS does not cancel their appointment or attempt to reschedule a follow up appointment we deem medically necessary, the patient may be dismissed from the practice.

4. Dismissal from the practice will be given in writing with 30 days for the patient to find a new physician and transfer their medical care and chart. Patients will be able to receive emergent medical care during that time period.

5. Dismissed patients may not be seen by the practice again.

Signature _____ Date _____

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