NEW PATIENT PAPERWORK

Jeffrey S. Haskel, DC, CNS Kelly J. Fredricks DC

Energetic Life Center

Please set aside at least 30 minutes to complete this paperwork and go over each question carefully allowing the doctors to better understand your case. They carefully review each question to better help you.

All paperwork needs to be completed and submitted to our office at least 24 hours prior to your first appointment. If it is not received, we will reschedule your appointment.

Name: | Birth Date: | Age: | Genger: ○ Male ○ Female

Address: | City: | State: | Zip:

E-mail Address: | Primary Phone: | Phone Carrier:

Do you have Insurance: ○ Yes ○ No | Insurance: | Member ID: | Gr #

Employer: | Occupation:

Marital Status: ☐ Single ☐ Married | Spouse's Name:

Height: | Weight: | Ethnicity: | Race:

Preferred Language:

☐ English ☐ Spanish ☐ French ☐ Italian ☐ Creole ☐ Other: _____

Emergency Contact Name: | Phone Number: | Relationship:

Who referred you to this office?

WHAT IS YOUR CHIEF COMPLAINT (MAIN REASON FOR COMING):

On a scale of 1 to 10 (10 being the best), what is your level of commitment to regaining your health?

○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

On a scale of 1 to 10, how willing are you to make lifestyle changes? (1=I don't want to change anything. 5= I will; make moderate changes, 10= I will do anything it takes!)

○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

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LIST SYMPTOMS IN ORDER OF PRIORITY (worst first):

Rate 1 → 10: 1 = Hardly There / 10 = Extremely Bad

Symptom & Description:	What makes it:		When Started:	Rating:
	Better	Worse		

Amount/level of:	Very Low	Low	Medium	High	Excessive	Erratic
General energy	☐	☐	☐	☐	☐	☐
Sleep	☐	☐	☐	☐	☐	☐
General appetite	☐	☐	☐	☐	☐	☐
General thirst	☐	☐	☐	☐	☐	☐
Circulation/warmth/heat	☐	☐	☐	☐	☐	☐
Daily exercise	☐	☐	☐	☐	☐	☐

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Exercise Routine

Energy is best:

☐ a.m. ☐ p.m. ☐ Night ☐ Between meals ☐ Just after meals ☐ When moving ☐ Or still

Energy is worst:

☐ a.m. ☐ p.m. ☐ Night ☐ Before meals ☐ Just after meals ☐ When moving ☐ Or still

Mind & Emotions (Check if current)

☐ Mood swings ☐ Anger/frustration ☐ Grief/sadness ☐ Racing mind ☐ Worry ☐ Fear ☐ Brain fog

☐ Poor memory ☐ Poor concentration ☐ Difficulty communicating

Stress: Current stress level between 1 and 10 (1 = very relaxed, 10 = very stressed): _____

Factors most contributing to your stress:

☐ Health ☐ Work ☐ Money ☐ Family ☐ Other _____

What best helps you deal with your stress?

Note: If you feel ready to be open in this area, the purpose of the following is to enable us to better assist your health.

Men & women (circle):

☐ Sexual impotence ☐ Lack of interest ☐ Genital discharge ☐ Swelling ☐ Testicular pain ☐ Other: _____

Women only: No. of children:_____ No. of miscarriages: _____ No. of abortions: _____ Length of time on the Pill: _____

Menses (circle):

☐ Late ☐ Early ☐ Regular ☐ Irregular ☐ Absent. Length of period _____ Time between periods _____

The flow has been:

☐ Heavy ☐ Light ☐ Regular

List any symptoms which are worse before / during (circle which):

☐ Infertility ☐ Pregnant now ☐ Planning pregnancy ☐ Difficult birth(s) ☐ Details: _____

Musculoskeletal Symptoms (Pain, Aches, Numbness and Tingling)

On a scale of 1 to 10 with 10 being the worst rate your health concerns by circling the number:

Primary or chief complaint is.:

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

When did the problem(s) begin?

Is it the result of ANY type of accident or injury?

◯ Yes ◯ No If so, please describe it: _____

When is the problem at its worst?

☐ AM ☐ PM ☐ Mid-day ☐ Late PM

How long does it last?

☐ It is constant OR ☐ I experience it on and off during the day OR ☐ It comes and goes throughout the week

Condition(s) ever been treated by anyone in the past?

◯ Yes ◯ No If yes, when? _____ by whom? _____

How long were you under care?

What were the results?

Name of Previous Chiropractor:

☐ N/A

Second complaint:

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Third complaint:

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Fourth complaint:

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

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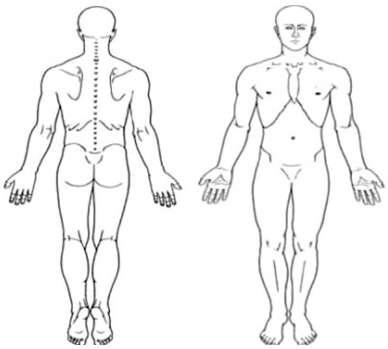
***PLEASE MARK** the areas on the Diagram with the following letters to describe your symptoms:

R =Radiating **B** =Burning **D** =Dull **A**= Aching **N** =Numbness **S** =Sharp/ Stabbing **T**= Tingling



What relieves your symptoms?

What makes them feel worse?

IDENTIFY ANY OTHER INJURY(S) TO YOUR SPINE, MINOR OR MAJOR, THAT THE DOCTOR SHOULD KNOW ABOUT:

ACTIVITIES OF LIFE

Please identify how your current condition is affecting your abil ity to carry out activities that are routinely part of your life:

ACTIVITIES:	EFFECT:			
Carrying Groceries	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sit to Stand	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Climbing Stairs	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Pet Care	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Driving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Extended Computer Use	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Household Chores	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Lifting Children	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Reading/ Concentration	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Bathing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Dressing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Shaving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sexual Activities	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sleep	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Static Sitting	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Static Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Yard work	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Walking	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sweeping/Vacuuming	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Dishes	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Laundry	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Garbage	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Lifting Groceries	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Other:	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform

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PAST HISTORY

Have you suffered with any of this or a similar problem in the past? ◯ Yes ◯ No If yes, how many times? _____

When was the last episode?_____ If any injury, how did it happen?(use back of sheet if needed) _____

_____

Other forms of treatment tried: ◯ Yes ◯ No If yes, please state what type of treatment: _____

and who provided it: _____ How long ago? _____ What were the results? ☐ Favorable ☐ Unfavorable

Please explain:

Please identify any and all types of jobs you have had in the past that have imposed any emotional, chemical, or physical stress on you or your body:

QUADRUPLE VISUAL ANALOGUE SCALE

Please read carefully:

Instructions: Please circle the number that best describes the question being asked. Please indicate your pain level right now, average pain, and pain at its best and worst

1- What is your pain RIGHT NOW?

No pain Worst possible pain

◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10

2 - What is your TYPICAL or AVERAGE pain?

No pain Worst possible pain

◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10

3 - What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?

No pain Worst possible pain

◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10

4- What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?

No pain Worst possible pain

◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10

OTHER COMMENTS:

Examine Reprinted from Spine, 18, Von Korff M, Deyo RA, Cherkin D, Barlow SF, Back pain in primary care: Outcomes at 1year,855-862, 1993, with permission from Elsevier Science.

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PAST TREATMENTS:

Approx. no. of courses of **Antibiotics** received in your life: ☐ 0 ☐ 1-10 ☐ 11-20 ☐ 21 +

For what? _____ When was last one received? _____

Approx. no. of **X-rays** received in your life: ☐ 0 ☐ 1-10 ☐ 11-20 ☐ 21 + When was last one received? _____

For what? (mammogram, injuries, dental, chest, etc ...) _____

Approx. no. of **Vaccinations** received in your life: ☐ 0 ☐ 1-10 ☐ 11-20 ☐ 21 +

Which ones? _____ When was last one received? _____

Briefly list your previous treatment / detoxification history (including conventional or alternative medicine):

WHEN BEGUN	WHEN ENDED	TREATMENT

HOSPITALIZATIONS / SURGERIES: (use additional sheet if needed)

INCIDENT	DATE	INCIDENT	DATE

ACCIDENTS:

Have you ever been knocked unconscious? Any blows to the head / spine / other injuries? Details: _____

CURRENT TREATMENTS: (use additional sheet if needed)

List medications you currently use (prescribed or over-the-counter): [BRING A SAMPLE OF EACH TO YOUR APPT]

NAME	FREQUENCY	DOSAGE	SINCE	WHEN

☐ Long-term medication(s) past / present (circle which). Details: _____

List all the supplements / homeopathies / herbs you are currently taking: [BRING SAMPLES OF THESE TOO]

NAME	FREQUENCY	DOSAGE	SINCE	WHEN

Is any other practitioner providing treatments/therapies for you at the present time? ○ YES ○ NO

Details: _____

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SYSTEMS CHECK

Check any current problems.

Sleep	☐ Probs. getting to sleep	☐ Freq. waking	☐ Early waking	☐ Wake unrefreshed	☐ Sleepiness
	☐ Night sweats				
Infections	☐ Recurring	☐ Frequent	☐ Colds	☐ 'Flu	☐ Sinusitis
	☐ Chest	☐ Ear	☐ Urethritis	☐ Cystitis	☐ Kidney
	☐ Stomach	☐ Food poisoning	☐ Poor immunity	☐ Sinus congestion	☐ Drip
	☐ Phlegm	☐ General 'run down' feeling			
Head	☐ Headaches	☐ Migraines	☐ Seizures	☐ Panic attacks	☐ Poor hearing
	☐ Ringing	☐ Visual Spots	☐ Confusion	☐ Blurred vision – distance/near	
General	☐ Nausea	☐ Swelling/edema	☐ Chronic fatigue	☐ Easily tired	
Lower back/kidney area	☐ Pain/soreness				
Chest	☐ Difficulty breathing	☐ Palpitations	☐ Burning	☐ Pain	☐ Angina
Urination	☐ Difficulty	☐ Incontinence	☐ Pain	☐ Frequent night visits to toilet	
Bowels	☐ Indigestion	☐ Heartburn	☐ Abdominal pain	☐ Bloating	☐ Gas
	☐ Rectal itching	☐ How often do you pass stools?_____			
Stools tend to be	☐ Okay	☐ Loose (L)	☐ Constipated (C)	☐ Alternating (L & C)	
Nerves, Muscles & Joints	☐ Burning	☐ Numbness	☐ Tingling	☐ Sensitivity	☐ Poor Mobility
	☐ Poor Co-ordination	☐ Muscle Weakness			
Recurring pain in	☐ Back	☐ Neck	☐ Shoulder	☐ _____	
Skin & Hair	☐ Eczema	☐ Psoriasis	☐ Rash	☐ Itchiness	☐ Dryness
	☐ Spots	☐ Athlete's foot	☐ Jock itch	☐ Hair loss	

MEDICAL HISTORY: PLEASE MARK **P** FOR IN THE PAST, **C** FOR CURRENTLY HAVE AND **N** FOR NEVER

	Anemia		Depression		High Blood Pressure		Prostate Problems
	Anxiety		Diabetes		Hip Pain		Rheumatic Fever
	Arrhythmia		Disability		Hyperlipidemia		Rheumatoid Arthritis
	Asthma		Dislocations		Irritable		Scarlet Fever
	Back Curvature		Dizziness		Jaw pain/TMJ		Scoliosis
	Bed Wetting		Fainting		Kidney Disease		Shortness of Breath
	Broken Bone		Foot or Knee Problems		Learning Disability		Shoulder Pain
	Bronchitis/Emphysema		Fracture		Liver Disease		Sinus/Drainage Problem.
	Cancer		Frequent Colds/Flu		Loss of Balance		Stroke/Tia's
	Caudication		Gastro-Intestinal Disorder		Low Blood Pressure		Swollen/Painful Joints
	Cerebral Vascular		Genito-Urinary Disorder		Mental Illness/Depression		Thyroid Disease
	Congenital Heart Disease		Gout		Osteo Arthritis		Tremors
	Congestive Heart Failure		Heart Attack		Pain with Cough/Sneeze		Tumors
	Convulsions/Epilepsy		Heart Murmur Pregnant (Now)		Ulcer		
	Veneral Disease		Other Serious Condition				

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FAMILY HISTORY	Father	Mother	Father's Parents	Mother's Parents	Siblings
HEART DISEASE	☐	☐	☐	☐	☐
HIGH BLOOD PRESSURE	☐	☐	☐	☐	☐
STROKE	☐	☐	☐	☐	☐
TUBERCULOSIS	☐	☐	☐	☐	☐
CANCER	☐	☐	☐	☐	☐
GLAUCOMA	☐	☐	☐	☐	☐
DIABETES	☐	☐	☐	☐	☐
EPILEPSY	☐	☐	☐	☐	☐
BLEEDING DISORDER	☐	☐	☐	☐	☐
KIDNEY DISEASE	☐	☐	☐	☐	☐
THYROID DISEASE	☐	☐	☐	☐	☐
MENTAL ILLNESS	☐	☐	☐	☐	☐

Your known allergies/sensitivities:

Please circle: ☐ Many ☐ Few ☐ Don't know

Details:

TOXICITY (other):

Do you smoke? ☐ Yes ☐ No Have you ever smoked (actively or passively)? ☐ Yes ☐ No

Packs daily _____ How long _____ When stopped _____

Have you used recreational drugs? ☐ Yes ☐ No Which _____ How long _____ When stopped _____

Have you ever been exposed to industrial/chemical toxins at work or home? (e.g. factory/farming…) ☐ Yes ☐ No

What chemicals/what industry/how long? _____ When stopped _____

Have you ever used weed killer or other agricultural chemicals? ☐ Yes ☐ No Do your neighbors? ☐ Yes ☐ No ☐ NO IDEA

Do you use a coal stove/fire (either regular or 'smokeless' coal)? ☐ Yes ☐ No Do your neighbors? ☐ Yes ☐ No ☐ NO IDEA

Do you live near any of the following (i.e. within about 1-2 miles, OR further if downwind) (Check which):

☐ A nuclear plant ☐ Crematorium ☐ Industrial zone ☐ Polluting factory ☐ Golf course ☐ Agricultural area?

Have you ever been exposed to any other known major environmental toxins? ☐ Yes ☐ No ☐ NO IDEA

If yes, explain: _____

DENTAL HISTORY:

Current no. of dental amalgam fillings (these are silver- or black-colored): _____

How long since the first one was placed? _____ Total number that have been removed: _____

When removed? _____ Removed by (check which): ☐ a regular dentist or ☐ a holistic mercury-free dentist?

Did your mother have amalgam fillings before your birth (check which)? ☐ YES ☐ NO ☐ PROBABLY ☐ NO IDEA

And did your father and/or grandparents (check which)? ☐ YES ☐ NO ☐ PROBABLY ☐ NO IDEA

No. of gold caps, root canals or other dental restorations (indicate which): _____

EMFs:

Your home is a (check which): ☐ House ☐ Apartment? Which apartment floor? _____ How many floors? _____

How far is the nearest: Cell phone mast _____ / Electricity tower _____ / Electrical substation _____ ?

Describe the view from your bedroom window: _____

Do you use (check which): ☐ Cordless phone ☐ Wi-Fi ☐ Electric: blanket, shaver , toothbrush ☐ Protective devices ☐ Magnets?

Are there fluorescent lights / strip lights / long-life (mercury) light bulbs in your (check which): ☐ Home ☐ Office ?

Do any adjacent neighbors have a cordless phone? ☐ Yes ☐ No ☐ NO IDEA

How many of these are in your home? TVs _____ Computers/laptops _____

Specifications of each: How many are LCD/LED? _____ vs. plain LCD? _____

Unsure? Write here all the screen names in full (use other sheet if needed) _____

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If using a laptop, do you use a corded external keyboard & mouse? ◯ Yes ◯ No

Do you use any telephones (check which): ☐ Held to ear ☐ On speakerphone function?

Type of heating used in home: _____ Which room do power lines enter? _____

Devices in your bedroom (check which): ☐ TV ☐ Computer ☐ Clock radio ☐ Lamp ☐ Cell phone ☐ Other appliances: _____

Average Hours of Use Per Day:

TV	Computer or tablet	Cell phone	Landline phone	In a motor vehicle

TRAVEL

Have you ever travelled to remote regions (eg: Asia/Africa/South America…) ◯ Yes ◯ No

Date	Destination(s)	Health Incidents There or After?

DIET

How much do you eat/drink of the following:	None	Very Little	Moderate	Very Much
Vegetables	☐	☐	☐	☐
Beans/legumes, nuts, seeds	☐	☐	☐	☐
Meat, fish (Which?	☐	☐	☐	☐
Chicken, turkey or eggs (not organic, even if free range)	☐	☐	☐	☐
Chicken, turkey or eggs (organic)	☐	☐	☐	☐
Dairy Foods (milk, cheese, yogurt, etc.)	☐	☐	☐	☐
White flour/starches: bread, pasta, potatoes, rice	☐	☐	☐	☐
Whole grains: wholewheat, oats, spelt, barley, rye	☐	☐	☐	☐
Candies (cakes, cookies, desserts, chocolate, sodas …)	☐	☐	☐	☐
Fruit and/or fruit juice	☐	☐	☐	☐

Average alcohol consumption per week: _____ ☐ History of alcohol addiction

Amount of water consumed daily (on its own): _____ Mark the type(s) of water you drink: ☐ Tap ☐ Filtered Tap ☐ Reverse Osmosis

☐ Distilled ☐ Alkaline ☐ Energized If so, energized how? _____ ☐ Bottled If so, which brand(s)? _____

☐ **I choose to decline receipt of my clinical summary after every visit (These summaries are often blank as the result of the nature and frequency of care.)**

I hereby authorize payment to be made directly to Jeffrey S. Haskel, D.C., P.A. for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and executing payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Jeffrey S. Haskel, D.C., P.A. for any and all services I receive at this office.

Patient or Authorized Person's Signature	Doctor's Signature
Date Completed	Date Form Reviewed

INFORMED CONSENT TO TREATMENT

I understand that Dr. Haskel, his licensed staff members and health consultants provide nutritional and other health-related information to help me attain my best health. All recommendations are designed to help me keep and enjoy my best state of health through personalized recommendations in lifestyle, exercise, health habits and advanced nutrition. I understand that Dr. Haskel, his licensed staff members and health consultants do not diagnose treat cure or claim to cure cancer or any other disease.

I also understand that Dr. Haskel or Dr. Fredricks will never tell me to stop taking medication. Any decision regarding medication is always between the patient and the prescribing physician. I also understand that Dr. Haskel, as well as being a Certified Nutritional Specialist Practioner®, is licensed as Doctor of Chiropractic Medicine in the state of Florida. Also, Dr. Fredricks is licensed as Doctor of Chiropractic Medicine in the state of Florida. If I choose to have any treatment that is allowed under this license, I am informed and consent to the following additional aspects of chiropractic treatment.

The nature of chiropractic treatment: Chiropractic care seeks to restore health through natural means without the use of medicine, surgery or other invasive means. Chiropractic care is not a substitute for traditional medical care, nor is traditional medical care a substitute for chiropractic. The doctor will use his/her hands or a mechanical device in order to move your joints. Various ancillary procedures, such as Low Intensity Laser Therapy, therapeutic exercise, mechanical massage, hot or cold electric muscle stimulation, therapeutic ultrasound or hydrotherapy may also be used. Nutritional supplements and dietary advice or offered to improve healing potential are also offered

Possible risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Rare complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, stroke or injury to intervertebral discs, nerves or spinal cord A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as''rare", about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered ''rare".

Other treatment options which could be considered may include the following: Over-the-counter analgesics. The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases. Medical care, typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.

Hospitalization in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.

Surgery in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

I have read the explanation above of the above treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risk and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and hereby give my full consent to treatment. I also have read and agree to the Consent or Use and Disclosure of Protected Health Information on File at Jeffrey S. Haskel, D.C., P.A.

Printed Name	Signature	Date

NEW PATIENT PAPERWORK

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RECORD REQUEST AND FINANCIAL RESPONSIBILTY AGREEMENT

Patient name:	SSN:	DOB:

Billing Address:	Phone

This is to certify that the above named patient authorizes the request of any records pertinent to the health care of same individual from but not inclusive of any insurance carrier, adjustor, attorney, or other health care provider.

This also authorizes this facility to release records, upon receipt of the above named patient's signature, or on an emergency basis, to, but not inclusive of, any insurance carrier, any attorney, health care provider, hospital or immediate family member.

This also certifies that the above named individual agrees to pay in full for all professional services rendered at the time they are performed, unless other arrangements are made in advance of the set appointment. The below named guarantor understands a $25.00 returned check fee will be charged along with any appropriate collection or attorney's fee which may accrue upon collection of any outstanding balance.

A photocopy of this agreement shall be considered as effective and valid as the original.

Privacy: The Standards for Privacy of Individually Identifiable Health Information ("Privacy Rule") establishes, for the first time, a set of national standards for the protection of certain health information. The U.S. Department of Health and Human Services Issued the Privacy rule to implement the requirement of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). A major goal of the Privacy Rule is to assure that Individuals' health Information is properly protected while allowing the flow of health information needed to provide and promote high quality health care and to protect the public's health and well-being. You can be assured that this facility takes your privacy seriously and is in compliance with all HIPAA guidelines. Your health information will not be disclosed without your permission or will your name, address or telephone number be disclosed to any third party.

Printed Name	Policyholder/Guarantor's signature	Date