PERSONAL INJURY QUESTIONNAIRE

Name: _____ Today's Date: _____

Date of Accident: _____

Where did accident happen? Describe the accident in your own words:

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 □ Right Rear □ Left Rear

Did your vehicle strike another vehicle □ Yes □ No

Was your vehicle struck by 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 vehicle at time of impact? □ Yes □ No

If yes, specify what part of your body struck what: ie… head chest chin 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

Immediately following the accident, how did you feel? □ dizzy/dazed □ disoriented □ unconscious

□ nervous □ nauseous □ upset □ weak □ Other _____

Did you go to hospital □ Yes □ No Were you admitted to the hospital? □ Yes □ No if yes how long? _____

If you went to hospital, when? □ At time of accident □ Next day

How did you get to hospital? □ Ambulance □ Police Car □ Private Transportation

Name of Hospital:_____

Attended by Dr. _____

… what treatment was given?

☐ none ☐ placed in a cervical collar ☐ x-rayed ☐ given stitches ☐ Bandaged

☐ given pain medication ☐ given instructions regarding concussions

☐ given instructions regarding sprains and strains ☐ Physical Therapy

☐ instructed to call a Orthopedic Surgeon ☐ instructed to call a private physician

☐ referred to this office for treatment ☐ Other _____

_____

Have you seen any other doctor as a result of this accident? □ Yes □ No

Doctor's name

Abundant Life Chiropractic Dr. Eric Harter
1611 Santa Barbara Blvd, Ste. 170 Cape Coral, FL 33991
Tel: 239-772-2266 Fax: 239-772-1017

CHIEF Complaints or Symptoms:

☐**Neck pain** check off the areas that the pain runs into from the neck ☐headache ☐Migraine Headache ☐upper back pain	☐none ☐left shoulder ☐left arm ☐left forearm ☐left hand ☐right shoulder ☐right arm ☐right forearm ☐right hand

Ringing in Ears	☐Yes ☐No	☐Left	☐Right	☐Both Ears	
Blurry Vision	☐Yes ☐No	☐Left	☐Right	☐Both Eyes	
Wrist Pain	☐Yes ☐No	☐Left	☐Right	☐Both Wrists	
Jaw Pain	☐Yes ☐No	☐Left	☐Right	☐Both Sides	

☐Dizziness ☐nervousness ☐fatigue ☐anxiety ☐depression ☐excessive irritability ☐fear of driving in a car ☐a loss of concentration ☐jaw clenching ☐grinding of teeth at night ☐ nightmares ☐difficulty with sleeping at night

☐**Low Back Pain** select the areas of radiation, if any...	☐none ☐buttocks ☐left buttock ☐left thigh ☐left knee ☐left foot ☐right buttock ☐right thigh ☐right knee ☐right foot

Hip Pain	☐Left	☐Right	☐Bilateral
Knee Pain	☐Left	☐Right	☐Bilateral
Foot Pain	☐Left	☐Right	☐Bilateral

Numbness:

☐ Left Hand	☐Left Upper Arm	☐Right Hand	☐Right Upper Arm
☐ Left Foot	☐Left Leg	☐Right Foot	☐Right Leg

Additional Symptoms/ Complaints:

Have You lost any time from work due to your injuries? ☐Yes ☐No

If yes please give dates: _____

Type of employment: _____

Have you had previous injuries or accidents? ☐Yes ☐ No

Description of previous Accident: _____

Description of previous injuries: _____

Is there any residual pain from the previous injury? ☐Yes ☐No

How much better did you feel prior to your current condition? (Example 100%, 80% etc.) _____

Welcome to Abundant Life Chiropractic

Dr. Eric Harter

Please Print Clearly and Fill In Completely:

Full Name: _____ **Email:** _____

Street Address: _____ **Phone:** _____

City: _____ **State:** _____ **Zip:** _____ **Date of Birth:** _____

Please Check: Sex: Male ☐ Female ☐ Last 4 Digits of SSN: _____

Status: Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated ☐

Health History:

Give reason for seeking chiropractic care: _____

_____

Describe any health problems, including how long you've had them: _____

_____

Are you under the care of any other doctor? Yes ☐ No ☐

If yes, the conditions being treated for:

_____

List any current medications: _____

List any past surgeries & dates: _____

List any past accidents & dates: _____

List any x-rays you've had in the past 2 years: _____

Personal & Family History:

Your Occupation: _____ Work Duties: _____

Spouse's health status: _____

Children's ages and health status: _____

Chiropractic History:

Have you ever been to a Chiropractor before? Yes ☐ No ☐ If yes, Doctor's Name _____

Date of last chiropractic visit: _____ Reason for care: _____

Date of last chiropractic x-rays: _____ How long were you under care? _____

☐ ☐

Wellness Commitment

At this Chiropractic office we are dedicated toward achieving the goal of total lasting health for our members. To better help you achieve this; we need to understand your commitment toward being healthy. We do *not* ask for a *financial commitment*, but we do ask for your *cooperative commitment*. Based on a scale of 10% to 100%, Please **circle** your personal level of commitment toward obtaining and maintaining health and wellness.

10%--------20%--------30%--------40%--------50%--------60%--------70%--------80%--------90%--------100%

Where did you hear about our clinic,
or who referred you? _____

FEMALES: ***Please Check One*** ☐ Is there a possibility of you being pregnant? **Yes** ☐ **No** ☐

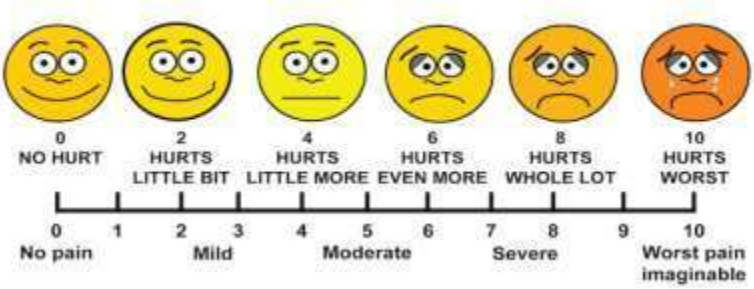
Abundant Life Chiropractic *Dr. Eric Harter*

If you have had the following or if you suffer from the following…

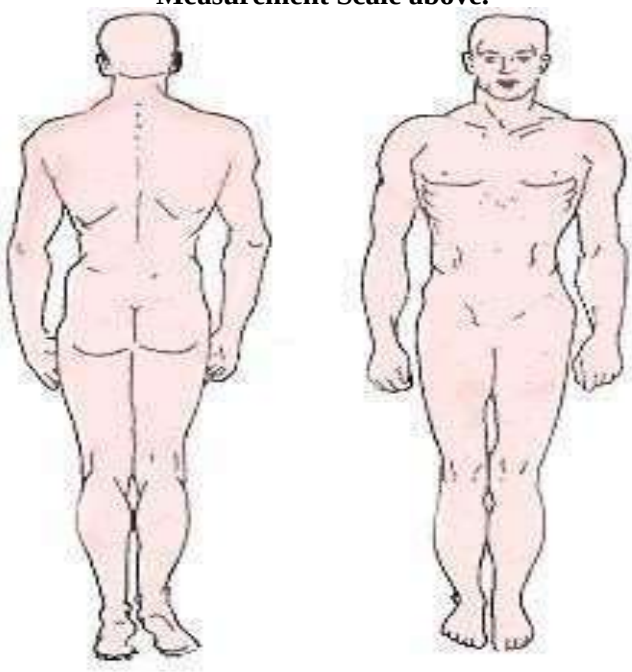
Please Check:

Condition, Symptom Or Problem	Constantly or Frequently	Sometimes or Occasionally
Headache		
Migraines	☐	☐
Neck Pain	☐	☐
Shoulder Pain	☐	☐
Arm/Hand Pain	☐	☐
Mid Back Pain	☐	☐
Low Back Pain	☐	☐
Hip Pain	☐	☐
Leg/Foot Pain	☐	☐
Disc Problems	☐	☐
Arthritis	☐	☐
Other joint pain	☐	☐
Numbness	☐	☐
Joint Swelling	☐	☐
Dizziness	☐	☐
Nausea	☐	☐
Weakness	☐	☐
Fatigue	☐	☐
Nervousness	☐	☐
Insomnia	☐	☐
Heart Problems	☐	☐
Frequent colds	☐	☐
Nose Bleeds	☐	☐
Ringing in Ears	☐	☐
Earaches	☐	☐
Hearing Loss	☐	☐
Cough	☐	☐
Chest pains	☐	☐
Female problems	☐	☐
Allergies	☐	☐
Asthma	☐	☐
Cancer	☐	☐
Osteoporosis	☐	☐
Diabetes	☐	☐
Hypoglycemia	☐	☐
Digestive problem	☐	☐
Urinary Problems	☐	☐
Skin conditions	☐	☐
Other _____	☐	☐

PAIN MEASUREMENT SCALE



Circle the areas where you have any problems. Please also scale these problems using the Pain Measurement Scale above.



Below, Please Fill In Any Other Health Information You Feel We Might Need For Your Care.

_____

_____

_____

_____

_____

Thank you for being complete and thorough.

Your Signature Below Please:

_____

Date: _____

1611 Santa Barbara Blvd. Suite #170 *Tel:(239)772-2266* *Fax:(239)772-1017*

NECK INDEX

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marketing the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Patient Name:_____ **Date:**_____

Pain Intensity
- □ I have no pain at the moment
- □ The pain is very mild at the moment
- □ The pain comes and goes and is moderate
- □ The pain is fairly severe at the moment
- □ The pain is very severe at the moment
- □ The pain is the worst imaginable at the moment

Sleeping
- □ I have no problem sleeping
- □ My sleep is slightly disturbed (less than 1 hour sleepless)
- □ My sleep is mildly disturbed (1-2 hours sleepless)
- □ My sleep is moderately disturbed (2-3 hours sleepless)
- □ My sleep is gradually disturbed (3-5 hours sleepless)
- □ My sleep is completely disturbed (5-7 hours sleepless)

Reading
- □ I can read as much as I want with no neck pain
- □ I can read as much as I want with slight neck pain
- □ I can read as much as I want with moderate neck pain
- □ I cannot read as much as I want because of moderate neck pain
- □ I can hardly rad at all because of severe neck pain
- □ I cannot read at all because of neck pain

Concentration
- □ I can concentrate fully when I want with no difficulty
- □ I can concentrate fully when I want with slight difficulty
- □ I have a fair degree of difficulty concentrating when I want
- □ I have a lot of difficulty concentrating when I want
- □ I have a great deal of difficulty concentrating when I want
- □ I cannot concentrate at all

Work
- □ I can do as much work as I want
- □ I can only do my usual work but no more
- □ I can only do most of my usual work but no more
- □ I cannot do my usual work
- □ I can hardly do any work at all
- □ I cannot do any work at all

Index Score = Sum of all statements selected / (# of selections with a statement selected x 5)] x 100

Personal Care
- □ I can look after myself normally without causing extra pain
- □ I can look after myself normally but it causes extra pain
- □ It is painful to look after myself and I am slow and careful
- □ I need some help but I manage most of my personal care
- □ I need help every day in most aspects of self-care
- □ I do not get dressed; I wash with difficulty and stay in bed

Lifting
- □ I can lift heavy weights without extra pain
- □ I can lift heavy weights but it causes extra pain
- □ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (i.e., on a table)
- □ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned
- □ I can only lift very light weights
- □ I cannot lift or carry anything at all

Driving
- □ I can drive my car without any neck pain
- □ I can drive my car as long as I want with slight neck pain
- □ I can drive my care as long as I want with moderate neck pain
- □ I cannot drive my car as long as I want because of moderate neck pain
- □ I can hardly drive at al because of sever neck pain
- □ I cannot drive my car at all because of neck pain

Recreation
- □ I am able to engage in all my recreation activities without neck pain
- □ I am able to engage in all of my usual recreation activities with some neck pain
- □ I am able to engage in most but not all my usual recreation activities because of neck pain
- □ I am only able to engage in a few or my usual recreation activities because of neck pain
- □ I can hardly do any recreation activities because of neck pain
- □ I cannot do any recreation activities at all

Headaches
- □ I have no headaches at all
- □ I have slight headaches which come infrequently
- □ I have moderate headaches with come infrequently
- □ I have moderate headaches with come frequently
- □ I have severe headaches which come frequently
- □ I have headaches almost all the time

Neck Index Score: _____

Abundant Life Chiropractic Dr. Eric Harter
1611 Santa Barbara Blvd, Ste. 170 Cape Coral, FL 33991
Tel: 239-772-2266 Fax: 239-772-1017

BACK INDEX

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marketing the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Patient Name:_____ **Date:**_____

Pain Intensity
- □ I have no pain at the moment
- □ The pain is very mild at the moment
- □ The pain comes and goes and is moderate
- □ The pain is fairly severe at the moment
- □ The pain is very severe at the moment
- □ The pain is the worst imaginable at the moment

Sleeping
- □ I have no problem sleeping
- □ My sleep is slightly disturbed (less than 1 hour sleepless)
- □ My sleep is mildly disturbed (1-2 hours sleepless)
- □ My sleep is moderately disturbed (2-3 hours sleepless)
- □ My sleep is gradually disturbed (3-5 hours sleepless)
- □ My sleep is completely disturbed (5-7 hours sleepless)

Reading
- □ I can read as much as I want with no back pain
- □ I can read as much as I want with slight back pain
- □ I can read as much as I want with moderate back pain
- □ I cannot read as much as I want because of moderate back pain
- □ I can hardly rad at all because of severe back pain
- □ I cannot read at all because of back pain

Concentration
- □ I can concentrate fully when I want with no difficulty
- □ I can concentrate fully when I want with slight difficulty
- □ I have a fair degree of difficulty concentrating when I want
- □ I have a lot of difficulty concentrating when I want
- □ I have a great deal of difficulty concentrating when I want
- □ I cannot concentrate at all

Work
- □ I can do as much work as I want
- □ I can only do my usual work but no more
- □ I can only do most of my usual work but no more
- □ I cannot do my usual work
- □ I can hardly do any work at all
- □ I cannot do any work at all

Index Score = Sum of all statements selected / (# of selections with a statement selected x 5)] x 100

Personal Care
- □ I can look after myself normally without causing extra pain
- □ I can look after myself normally but it causes extra pain
- □ It is painful to look after myself and I am slow and careful
- □ I need some help but I manage most of my personal care
- □ I need help every day in most aspects of self-care
- □ I do not get dressed; I wash with difficulty and stay in bed

Lifting
- □ I can lift heavy weights without extra pain
- □ I can lift heavy weights but it causes extra pain
- □ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (i.e., on a table)
- □ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned
- □ I can only lift very light weights
- □ I cannot lift or carry anything at all

Driving
- □ I can drive my car without any back pain
- □ I can drive my car as long as I want with slight back pain
- □ I can drive my care as long as I want with moderate back pain
- □ I cannot drive my car as long as I want because of moderate back pain
- □ I can hardly drive at al because of sever back pain
- □ I cannot drive my car at all because of back pain

Recreation
- □ I am able to engage in all my recreation activities witheout back pain
- □ I am able to engage in all of my usual recreation activities with some back pain
- □ I am able to engage in most but not all my usual recreation activities because of back pain
- □ I am only able to engage in a few or my usual recreation activities because of back pain
- □ I can hardly do any recreation activities because of back pain
- □ I cannot do any recreation activities at all

Headaches
- □ I have no headaches at all
- □ I have slight headaches which come infrequently
- □ I have moderate headaches with come infrequently
- □ I have moderate headaches with come frequently
- □ I have severe headaches which come frequently
- □ I have headaches almost all the time

Back Index Score: _____

Abundant Life Chiropractic Dr. Eric Harter
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OFFICE OF INSURANCE REGULATION
Bureau of Property & Casualty Forms and Rates

Standard Disclosure and Acknowledgement Form
Personal Injury Protection - Initial Treatment or Service Provided

The undersigned insured person (or guardian of such person) affirms:

1. The services or treatment set forth below were **actually rendered.** This means that those services have **already been provided.**

Chiropractic adjustment, manual therapy, therapeutic exercises, hot/cold therapy, massage therapy, exam, mechanical traction

extra-spinal manipulation, ultra-sound, e-stim

2. I have the right and the **duty to confirm** that the services have already been provided.

3. I was **not solicited** by any person to seek any services from the medical provider of the services described above.

4. The medical provider has **explained** the services to me for which payment is being claimed.

5. If I notify the insurer in writing of a billing error, I may be entitled to a portion of any reduction in the amounts paid by my motor vehicle insurer. If entitled, my share would be at least 20% of the amount of the reduction, up to $500.

Insured Person (patient receiving treatment or services) or Guardian of Insured Person:

Name *(PRINT or TYPE)*	Signature	Date

The undersigned licensed medical professional or medical director, if applicable, affirms the statement numbered 1 above and also:

A. I have **not solicited** or caused the insured person, who was involved in a motor vehicle accident, to be solicited to make a claim for Personal Injury Protection benefits.

B. The treatment or services rendered were explained to the insured person, or his or her guardian, **sufficiently** for that person to sign this form with informed consent.

C. The accompanying statement or bill is **properly completed** in all material provisions and all relevant information has been provided therein. This means that each request for information has been responded to **truthfully, accurately**, and in a **substantially complete** manner.

D. The coding of procedures on the accompanying statement or bill is proper. This means that **no service has been upcoded, unbundled**, or constitutes an invalid **or not medically necessary diagnostic test** as defined by Section 627.732 (15) and (16), Florida Statutes or Section 627.736(5)(b)6, Florida Statutes.

Licensed Medical Professional Rendering Treatment/Services or Medical Director, if applicable *(Signature by his/ her **own hand**):*

Name *(PRINT or TYPE)*	Signature	Date

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of Claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree per Section 817.234(1)(b), Florida Statutes.

Note: The **original** of this form must be furnished to the insurer pursuant to Section 627.736(4)(b), Florida Statutes and may **not** be electronically furnished. Failure to furnish this form may result in non-payment of the claim.

Abundant Life Chiropractic
Dr. Eric Harter, DC
1611 Santa Barbara Blvd, Ste 170,
Cape Coral, FL 33991
Tel: 239-772-2266 Fax: 239-772-1027

Patient Name (Print): _____

ASSIGNMENT OF INSURANCE BENEFITS:

I hereby authorize payment to be made directly to Dr. Eric Harter, LLC of all benefits which may be due and payable under insurance coverage for the above named patient. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments. I further acknowledge that this assignment of benefits does not in any way relieve me of the liability and that I will remain financially responsible to Dr. Eric Harter, LLC.

Furthermore, I hereby irrevocably assign to Dr. Eric Harter, LLC the rights and benefits under any policy of insurance, indemnity agreement or any other collateral source as defined in Florida Status for any services and/or charges provided by Dr. Eric Harter, LLC.

AUTHORIZATION TO RELEASE MEDICAL RECORD INFORMATION:

Dr. Eric Harter, LLC is hereby authorized to disclose all or any of the medical records on the above named patient to such insurance companies, organizations or agencies as may be responsible for payment or services rendered by Dr. Eric Harter, LLC. This authorization is given with full knowledge that such disclosure may contain information of a confidential nature and may result in a denial of insurance coverage for services rendered by said Dr. Eric Harter, LLC.

The undersigned certifies that he or she has read and understands each of the above paragraphs and is the patient responsible party with the power to execute this document and accept these terms.

Signature of Patient or Responsible Party: _____Date:_____

Signature of Witness: _____Date:_____

ABUNDANT LIFE CHIROPRACTIC
Dr. Eric Harter, DC
1611 Santa Barbara Blvd, Ste. 170,
Cape Coral, FL 33991
Tel: 239-772-2266 Fax: 239-772-1027

FEE GUARANTEE AGREEMENT

PATIENT NAME: _____

DATE OF ACCIDENT: _____

MEDICAL PROVIDER: _____

I, _____, the above noted Patient, do hereby authorize and direct my present and any future attorney to honor this fee guarantee agreement. This agreement is made in favor of the above named Medical Provider and shall be termed a "Letter of Protection." The Letter of Protection shall serve to place a continuing lien on any proceeds I recover in any legal action related to the above noted accident date.

Consideration. In consideration of the medical treatment provided and time provided to pay for said medical treatment, I hereby grant a direct lien on any and all funds I may recover in any legal action related to the above accident date.

Protection of Outstanding Charges. The above-named Patient hereby agrees that if s/he recovers any money from any person or entity in connection with any legal action related to the above noted accident date, the Patient shall withhold from those funds, sufficient money pay the full outstanding balance of any bill(s) owed to the above named Medical Provider for treatment or any work completed in relation to the above noted accident date and without regard to any suggested peer review or insurance company reduction. Those funds shall be deducted prior to any other party removing funds for any reason, including but not limited to attorney's fees, costs, other court fees, or any other bill or lien whatsoever. Patient hereby directs their present and/or future attorney to pay said outstanding medical bill in connection with the above noted treatment. This agreement shall obligate each attorney who represents the above named patient in any way and recovers any funds related to the above noted accident date and creates a constructive trust with said attorney. Further, this agreement shall

extend pay any outstanding balance for any copies, costs or reports the above named Medical Provider endures in relation to any legal issue for the above accident date. The Patient hereby agrees to waive any rights they have, under contract, law or equity, to have the Medical Provider bill a third party entity, including but not limited to any contracted payer, health insurer or government payer and further desires to pay for the medical treatments through the legal action's proceeds.

Patient Responsibility. It is the Patient's responsibility to advise each and every attorney of the existence of this agreement. Further the Patient must advise the above named Medical Provider at reasonable intervals the status of the legal case. It is also the Patient's responsibility to advise the Medical Provider within 5 days of legal matter collecting any funds and to request a bill for any and all outstanding charges. The Patient hereby directs their present attorney and any future attorney to advise the Medical Provider, as soon as possible, about any funds related to the accident case becoming available to the above named Patient. Further, if the legal action fails to fully pay the Medical Provider's outstanding balance(s) then the remaining amounts are to be paid by the Patient. The Medical Provider may, at his/her discretion at any time, bill any third party payer or government payer.

Disputes. If there is a dispute over the Medical Provider's outstanding charges the Patient agrees to submit the full amount due to the Medical Provider and agrees to bring an action in Florida State Court for recovery of the disputed difference. If the Patient fails to pay the Medical Provider's full outstanding balance, and thereafter Medical Provider brings suit to collect said sums, Medical Provider shall then have the right to recover attorney fees and costs for bringing an action to enforce this particular provision.

Approval Required. This agreement becomes effective when the Patient signs the agreement below. This agreement does not need the approval of any present or future attorney for the Patient.

The parties agree that no party shall be considered the drafting party to this contract.

Patient Signature: _____ Date: _____

THIS NOTICE DESCRIBES HOW OUR OFFICE MAY USE AND DISCLOSE YOUR PERSONAL INFORMATION AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

In the course of your care as a patient at our office, we may' use or disclose personal and health related information about you in the following ways:

"Your protected health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment, or treatment."

"Your health care records, as well as your billing records', may be disclosed to another party, such as an insurance carrier, and HMO, a PPO, or your employer, if they are or may be responsible for the payment or services provided to you. "

"You have a right to request restriction on our use of your protected health information for treatment, payment, and operations purposes. Such requests are not automatic and require the agreement of this office. "

"Your name, address, telephone number, e-mail address, and health records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you. "

"If you are not home to receive and appointment reminder or other related information, a message may be left on you answering machine or with a person in your household. You have a right to confidential communications and to request restrictions relative to such contacts. You also have the right to be contacted by alternative means or at alternative locations."

We are permitted and may be required to use or disclose your health information without your authorization in these following circumstances:

"'If we provide health care services to you in an emergency. "

"If we are required by law to provide care to you, and we are unable to obtain your consent after attempting to do so. "

"If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care. "

*If we are ordered by the courts or another appropriate agency. "

"You have a right to receive an accounting of any such disclosures made by this office. "

Any us or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization. If you provide an authorization for release of information, you have the right to revoke that authorization at a later date.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail and e-mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home or if you would like the information in a specific form, please advise us in writing as to your preferences.

You have the right to inspect and! or copy your; health information for as long as the information remains in our files. In addition, you have the right to request an amendment to your health information. Requests to inspect, copy or amend your health related information should be provided to us in writing. :

We are required by state and federal law to maintain the privacy of your patient file and the protected health information therein.

We are also required to provide you with this notice of our privacy practices with respect to your health information. We are further required by law to abide by the terms of this notice while it is in effect.

We reserve the right to alter the terms of this privacy notice. If changes are made to our privacy notice, we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files.

If you have a complaint regarding our privacy notice, our privacy practices, or any aspect of our privacy activities, you should direct your complaint to Dr. Eric Harter.

If you would like further information about our: privacy policies and practices, please contact Dr. Eric Harter. You also have the right to lodge a complaint with the Secretary of the Department of Health and Human Services. If you choose to lodge a complaint with this office or with the Secretary, you care will continue and you will not be disadvantaged by this office or our staff in any manner whatsoever. Effective as of 04/15/03.

This notice and any alterations of amendments made hereto will expire seven years after the date upon which the record was created.

Name (printed) Signature; Date

If you are a minor, or if you are being represented by another party:

Personal Representative Name {print} Signature Date

ABUNDANT LIFE CHIROPRACTIC

Dr. Eric Harter
1611 Santa Barbara Blvd, Ste. 170
Cape Coral, FL 33991
Tel: 239-772-2266 Fax: 239-772-1017

INFORMED CONSENT FORM

I hereby request and consent to the performance of chiropractic adjustment and other chiropractic procedures, including various modes of posture correction and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named above and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed above or any other office or clinic.

I have had an opportunity to discuss with the doctor or chiropractic named above and/or with the other office or clinic personnel 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 upon the doctor to exercise judgement during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her is in my best interest.

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 and for any future condition (s) for which I seek treatment.

Patient Signature: _____ **Date:** _____

Witness Signature: _____ **Date:** _____

ABUNDANT LIFE CHIROPRACTIC

Dr. Eric Harter
1611 Santa Barbara Blvd, Ste. 170
Cape Coral, FL 33991
Tel: 239-772-2266 Fax: 239-772-1017

ASSUMPTION OF RISK, RESPONSIBILITY AND LIABILITY WAIVER

I agree as follows:

Assumption of Risks:
I understand that during chiropractic visit (s) at Abundant Life Chiropractic and Dr. Eric L. Harter, Inc., I will be in unfamiliar surroundings and will be exposed to risks to my person and possessions. 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 upon the doctor to exercise judgement during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest. Accordingly, I understand that despite its efforts, Abundant Life Chiropractic and Dr. Eric L. Harter, Inc. may not be able to ensure my complete safety at all times from such risks.

Assumption of Responsibility:
I understand that it is my responsibility for payment at the end of service and no insurance will be billed.

Liability Waiver:
I release and hold harmless Abundant Life Chiropractic and Dr. Eric L. Harter, Inc., their employees from any and all liability for any loss, damage, injury or expense that I may suffer as a result of my chiropractic visit (s) including, but not limited to, accidents, scheduling, sickness, government restrictions or regulations, any and all expenses which I may occur while participating in the chiropractic visit (s).
In the event one or more of the provisions of this waiver is deemed to be invalid, illegal or unenforceable in any respect under applicable law; the validity, legality and enforceability of the remaining provisions hereof shall not in any way be impaired thereby.
This waiver is effective while I am a patient and participating in the chiropractic visit (s). I understand that this agreement cannot be modified or interpreted except in writing by Abundant Life Chiropractic and Dr. Eric L. Harter, Inc. and no oral modification or interpretation shall be valid.

I have read this document carefully and acknowledge my responsibility and the effect of this liability waiver.

Patient Signature: _____ **Date:** _____