PATIENT INFORMATION FORM

TODAY'S DATE:_____

LAST NAME:_____FIRST NAME:_____MI:_____

DATE OF BIRTH:_____ GENDER M [ ] F [ ] SS#(LAST4):_____

DRIVER'S LICENSE#:_____

EMAIL:_____

CELL#:_____HOME#:_____WORK#:_____

STREET ADDRESS:_____

CITY:_____STATE:_____ZIP:_____

OCCUPATION:_____

EMPLOYER:_____YEARS EMPLOYED:_____

SPOUSE'S NAME:_____SS#(LAST4):_____DATE OF BIRTH:_____

REFERRED BY:_____

REASON FOR VISIT:_____

_____

PRIMARY PHYSICIAN:_____

MAY WE SHARE YOUR CLINICAL INFORMATION WITH YOUR PRIMARY PHYSICIAN? Y [ ] N [ ]

_____

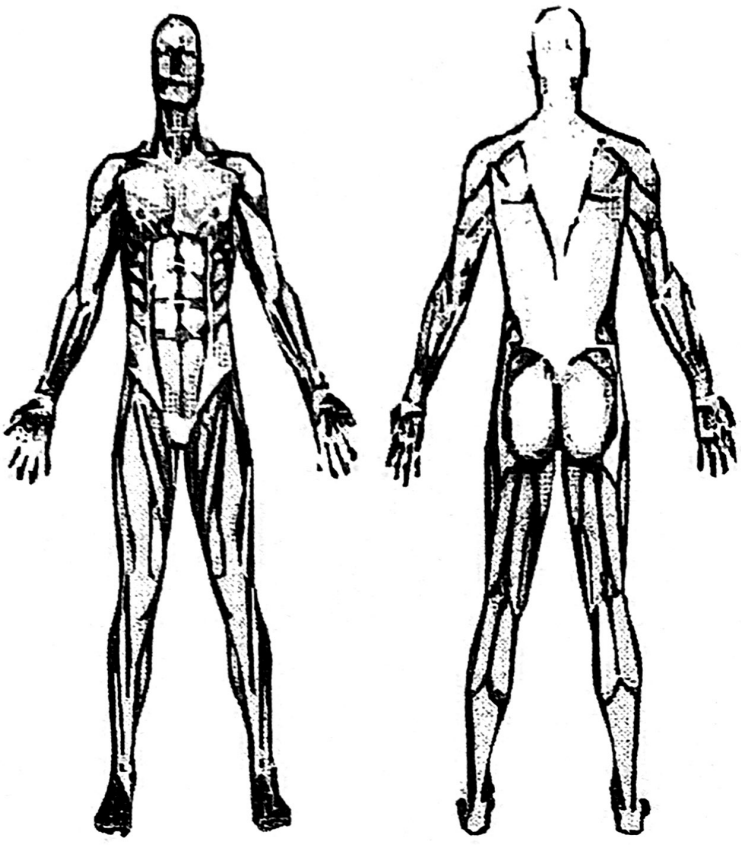
_____

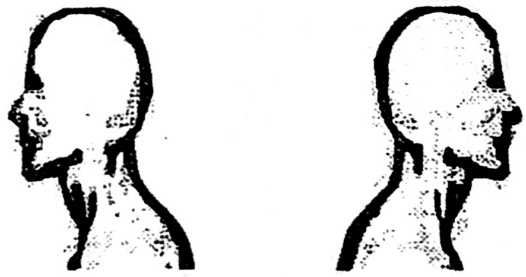
_____

I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED TO ME ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT. I ALSO UNDERSTAND THAT IN THE EVENT THAT THE INSURANCE CARRIER(S) DOES(DO) NOT DIRECT PAYMENT TO MY DOCTOR, I WILL BE PERSONALLY RESPONSIBLE FOR PAYMENT.

PATIENT/GUARDIAN SIGNATURE:_____**DATE:**_____

PLEASE MARK AREAS OF CONCERN





DR MARK KENNEDY DC

23412 Moulton Parkway #130 Laguna Hills CA 92653 **949.829.8871**

ASSUMPTION OF THE RISK AND WAIVER OF LIABILITY RELATING TO CORONAVIRUS / COVID-19

The novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization. COVID-19 is extremely contagious and is believed to spread mainly from person-to-person contact. As a result, federal, state, and local governments and federal and state health agencies recommend social distancing and have, in many locations, prohibited the congregation of groups of people. Dr Mark Kennedy DC has put in place preventative measures to reduce the spread of COVID-19; however, we cannot guarantee that you or your family will not become infected with COVID-19. Further, visiting our office could increase your and your family's risk of contracting COVID-19.

By signing this agreement, I acknowledge the contagious nature of COVID-19 and voluntarily assume the risk that my family and I may be exposed to or infected by COVID-19 by visiting Dr Mark Kennedy DC and that such exposure or infection may result in personal injury, illness, permanent disability, and death. I understand that the risk of becoming exposed to, or infected by COVID-19 at Dr Mark Kennedy DC may result from the actions, omissions, or negligence of myself and others, including, but not limited to, Dr Mark Kennedy DC, employees, vendors & other Dr Mark Kennedy DC patients. I voluntarily agree to assume all of the foregoing risks and accept sole responsibility for any injury to myself or my family (including, but not limited to, personal injury, disability, and death), illness, damage, loss, claim, liability, or expense, of any kind, that my family and I may experience or incur in connection with our visits at Dr Mark Kennedy DC. On my behalf, and on the behalf of my family, I hereby release covenant not to sue, discharge, and hold harmless Dr Mark Kennedy DC, its employees, agents, and representatives, of and from the Claims, including all liabilities, claims, actions, damages, costs or expenses of any kind arising out of, or relating thereto. I understand and agree that this release includes any Claims based on the actions, omissions, or negligence of Dr Mark Kennedy DC, its employees, agents, and representatives, whether a COVID-19 infection occurs before, during, or after any treatment at our office.

_____

PATIENT NAME (PRINT)

_____

PATIENT'S SIGNATURE DATE

_____

SIGNATURE OF PARENT OR GUARDIAN (IF MINOR) DATE

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures, if indicated. Any examinations or tests conducted will be carefully performed, but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including, but not limited to, hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an arterial dissection that involves an abnormal change in the wall of an artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. This occurs in 3-4 of every 100,000 people, whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately, a percentage of these patients will experience a stroke. As chiropractic can involve manually and/or mechanically adjusting the cervical spine, it has been reported that chiropractic care may be a risk for developing this type of stroke. The association with stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____ Signature: _____ Date: _____

Parent or Guardian: _____ Signature: _____ Date: _____

Witness Name: _____ Signature: _____ Date: _____

PATIENT NAME:

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California and federal law, and not by a lawsuit or resort to court process except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. Further, the parties will not have the right to participate as a member of any class of claimants, and there shall be no authority for any dispute to be decided on a class action basis. An arbitration can only decide a dispute between the parties and may not consolidate or join the claims of other persons who have similar claims.

Article 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, as to whether this agreement is unconscionable, and any procedural disputes, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers, preceptors, or interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages. This agreement is intended to create an open book account unless and until revoked.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days, and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit. Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder, any existing court action against such additional person or entity shall be stayed pending arbitration. The parties agree that provisions of the California Medical Injury Compensation Reform Act shall apply to disputes within this arbitration agreement, including, but not limited to, sections establishing the right to introduce evidence of any amount payable as a benefit to the patient as allowed by law (Civil Code 3333.1), the limitation on recovery for non-economic losses (Civil Code 3333.2), and the right to have a judgment for future damages conformed to periodic payments (CCP 667.7). The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: General Provision: All claims based upon the same incident, transaction, or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and, if not revoked, will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment), patient should initial here. _____. Effective as of the date of first professional services.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

Patient Name: _____ Signature: _____ Date: _____

Parent or Guardian: _____ Signature: _____ Date: _____

Witness Name: _____ Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES

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

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires individually identifiable health information used or disclosed by us, whether electronically, on paper, or orally, be kept properly confidential. HIPAA gives the patient significant new rights to understand and control how health information is used. It also provides penalties for covered entities that misuse personal health information.

We may use and disclose your medical records only for the following purposes:

- **Treatment.** Providing, coordinating, or managing health care and related services by one or more health care providers.
- **Payment.** Obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review.
- **Health Care Operations.** Conducting quality assessment and improvement activities, auditing, cost-management analysis, and providing customer service.

We may also create and distribute de-identified health information by removing all individually identifiable information.

We may contact you to provide appointment reminders, information about treatment alternatives, or other health-related benefits and services, which might be of interest to you.

Any other uses and disclosures may be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that request, except to the extent that we have already taken actions relying on your authorization.

<u>You have the following rights, which you can exercise by presenting a written request to our office.</u>

- To request restrictions on certain uses and disclosures of protected health information. This includes disclosures to family members, other relatives, personal friends, or other persons identified by you. We are not required to agree to requested restrictions. However, if we do agree to a restriction, we are obligated to abide by it unless you agree in writing to remove it.
- To a reasonable request to receive confidential communications from us by alternative means or at alternative locations.
- To inspect and copy your protected health information.
- To amend your protected health information.
- To receive an accounting of disclosures of protected health information.
- To obtain a paper copy of this notice upon request.

This notice is effective as of _____, 20___ and we are required to abide by the terms of the *Notice of Privacy Practices* currently in effect. We reserve the right to change the terms of our *Notice of Privacy Practices* and to make new notice provisions effective for all protected health information that we maintain. You may request a written copy of a revised *Notice of Privacy Practices* from this office.

Should you feel your privacy protections have been violated, you may file a written complaint, about violations of the provisions of this notice or of the policies and procedures of our office, with this office or with the Department of Health & Human Services, Office of Civil Rights (address below). We will not retaliate against you for filing a complaint.

Please contact us for more information. For more information about HIPAA contact:
The U.S. Dept. of Health & Human Services, Office of Civil Rights, 200 Independence Ave. SW, Washington, D.C. 20201. PHONE: (202) 619-0257 or toll free (877) 696-6775.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name:_____ **Signature**_____ **Date**_____