



ACTIVE PERFORMANCE CARE
 6817 Southpoint Parkway, Suite #303 Jacksonville, FL 32216
 PATIENT REGISTRATION INFORMATION

PATIENT INFORMATION:

Name: _____ Age: _____ Sex: M or F Handed: L or R
First MI Last

Address: _____ City: _____ State: _____ Zip: _____

Home Phone # _____ Work Phone # _____ Cell Phone # _____

SSN: _____ - _____ - _____ DOB: ___/___/___ Present Employer: _____ Marital Status: S M D W

Emergency Contact: _____ Relationship: _____ Phone # (____) _____ - _____

Responsible Party (if minor): _____ Phone # (____) _____ - _____

Address: _____ City: _____ State: _____ Zip: _____

Email: _____ YES NO I want to receive emails that include educational articles and promotions

Primary Care Physician: _____ Phone # (____) _____ - _____

Date of Accident/Injury: ___/___/___ Referring Physician: _____ Phone # (____) _____ - _____

How did you hear about us? ART Website – Article/Ad – Event or personal reference: _____

INSURANCE INFORMATION: We are out of network with all insurance companies, as a courtesy we file claims monthly for any reimbursement you may receive from your carrier.

Primary:

Carrier Name: _____

Phone # (____) _____ - _____

Contact: _____

Subscriber Name: _____

Work Phone # (____) _____ - _____

SSN: _____ - _____ - _____ DOB: ___/___/___

Relationship to Subscriber: _____

Group # _____

Policy # _____

Secondary:

Carrier Name: _____

Phone # (____) _____ - _____

Contact: _____

Subscriber Name: _____

Work Phone # (____) _____ - _____

SSN: _____ - _____ - _____ DOB: ___/___/___

Relationship to Subscriber: _____

Group # _____

Policy # _____

CIRCLE ALL BODY AREAS THAT CURRENTLY CAUSE DISCOMFORT (Left, Right, or Both)

Shoulder	L R B	Elbow	L R B	Wrist	L R B	Hand	L R B	Neck
Finger	L R B	Hip	L R B	Knee	L R B	Ankle	L R B	Upper Back
Foot	L R B	Toe	L R B	Arm	L R B	Leg	L R B	Lower Back



PERSONAL HISTORY

Patient Name: _____ Date: _____

Chief Complaint/Symptoms: _____

Other doctors seen for this condition: Yes No If Yes, whom? _____

Type of treatment: _____ Results: _____

When did this condition begin? _____ Has this condition occurred before? Yes No When is the pain the most severe? _____

What makes it better? _____ What makes it worse? _____

Condition related to: Work Auto Home injury Sports Fall Other: _____

If work related, have you made a report of your accident to your employer? Yes No Date and time of accident: _____

All prescription/non-prescription medications and vitamins you currently take: _____

Do you suffer from any condition other than which you are now consulting us? _____

PAST HEALTH HISTORY - PLEASE CHECK AND/OR DESCRIBE

Surgery/Operations: Appendectomy Tonsillectomy Gall Bladder Hernia Neck/Back Surgery Hysterectomy Broken Bones
 Other _____

Major Accidents, Traumas, or Falls: _____

Hospitalizations (Other than above): _____

Previous Chiropractic Care: None Doctor's name and approximate date of last visit: _____

Below is a list of diseases that may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE OR HAD:

<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Mumps	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Small Pox	INTAKE	Amount/day
<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Polio	<input type="checkbox"/> Tuberculosis	Water	_____
<input type="checkbox"/> Whooping Cough	<input type="checkbox"/> Anemia	<input type="checkbox"/> Measles	<input type="checkbox"/> Cancer	Coffee	_____
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Thyroid	<input type="checkbox"/> Influenza	<input type="checkbox"/> Pleurisy	Tea	_____
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Mental Disorders	<input type="checkbox"/> Lumbago	Cola	_____
<input type="checkbox"/> Eczema	<input type="checkbox"/> HIV	<input type="checkbox"/> AIDS	<input type="checkbox"/> Hepatitis A,B,C,D,E	Alcohol	_____
				Tobacco	_____

Do you exercise? Yes No If yes, type and frequency _____

PLEASE CHECK AND/OR CIRCLE ANY OF THE FOLLOWING YOU HAVE HAD IN THE PAST 6 MONTHS:

Musculo-Skeletal	Gastro-Intestinal	C-V-R	EENT
<input type="checkbox"/> Low Back Pain	<input type="checkbox"/> Poor/Excessive Appetite	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Hearing Difficulty/Ear Aches
<input type="checkbox"/> Pain between Shoulders	<input type="checkbox"/> Excessive Thirst	<input type="checkbox"/> Short Breath	<input type="checkbox"/> Vision/Dental Problems
<input type="checkbox"/> Neck Pain	<input type="checkbox"/> Frequent Nausea	<input type="checkbox"/> Blood Pressure Problem	<input type="checkbox"/> Difficulty Swallowing
<input type="checkbox"/> Arm Pain	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Irregular Heartbeat	Female
<input type="checkbox"/> Joint Pain/Stiffness	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Menstrual Irregularity
<input type="checkbox"/> Walking Problems	<input type="checkbox"/> Constipation	<input type="checkbox"/> Lung Problems/Congestion	<input type="checkbox"/> Menstrual Cramps
<input type="checkbox"/> Difficulty Chewing/Jaw click	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Varicose Veins	<input type="checkbox"/> Vaginal Pain/Infection
<input type="checkbox"/> General Stiffness	<input type="checkbox"/> Liver Problems	<input type="checkbox"/> Ankle Swelling	<input type="checkbox"/> Breast Pain/Lumps
Nervous System	<input type="checkbox"/> Gall Bladder Problems	<input type="checkbox"/> Stroke	<input type="checkbox"/> Other _____
<input type="checkbox"/> Nervousness	<input type="checkbox"/> Weight Control Problems	General	When was your last period? _____
<input type="checkbox"/> Numbness	<input type="checkbox"/> Abdominal Cramps	<input type="checkbox"/> Fatigue	Are you pregnant? Y N not sure
<input type="checkbox"/> Paralysis	<input type="checkbox"/> Gas/Bloating After Meals	<input type="checkbox"/> Allergies	Male
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Heartburn	<input type="checkbox"/> Loss of Sleep	<input type="checkbox"/> Testicular Pain
<input type="checkbox"/> Forgetfulness	<input type="checkbox"/> Black/Bloody Stool	<input type="checkbox"/> Fever	<input type="checkbox"/> Prostate/Sexual Dysfunction
<input type="checkbox"/> Confusion/Depression	<input type="checkbox"/> Colitis	<input type="checkbox"/> Headaches	<input type="checkbox"/> Nocturia (waking up to use toilet)
<input type="checkbox"/> Fainting/Convulsions	Genito-Urinary		<input type="checkbox"/> Other _____
<input type="checkbox"/> Cold/Tingling Extremities	<input type="checkbox"/> Bladder Trouble/Discolored Urine		
<input type="checkbox"/> Stress	<input type="checkbox"/> Painful/Excessive Urination		

FAMILY HISTORY

Relationship	Name	Age	Health Problem(Cancer, Diabetes, Heart Disease. Etc.)



**LIFETIME AUTHORIZATION STATEMENT
ASSIGNMENT OF BENEFITS FOR DIRECT PAYMENT**

Patient Name: _____ Date: _____

Please review the following LifetimeAuthorizationStatement. Please do not hesitate to ask a staff member for clarification on any part of this document. Please sign where indicated and return it to the receptionist. If you disapprove, we certainly respect your right of refusal. However, please be aware that, without your legal signature, we cannot file with your insurance carrier for the services you are scheduled to receive. Therefore, we will have no alternative but to require that you be responsible for the services rendered in full. (See reverse side for RefusaltoSignLifetimeAuthorizationStatement). Thank you in advance for your cooperation.

LIFETIME AUTHORIZATION STATEMENT/ASSIGNMENT FOR DIRECT PAYMENT

This is a direct assignment of my rights and benefits under this policy. This payment will not exceed service charges over and above this insurance payment, including applicable co-payments, deductible, non-covered services and items, unauthorized services or any fees denied, except to the extent my liability for any such balance is limited by agreement or law applicable to Active Performance Care. A photocopy of this assignment shall be considered as effective and as valid as the original.

I understand and agree that health and accidental insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse co- issued remittances for the conveyance of credit to my account. However, 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 if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. I understand that a missed appointment or cancellation without 24 hours notice may result in a charge of \$50.00.

RELEASE OF MEDICAL RECORDS

I hereby authorize Active Performance Care to release any medical information in connection with these services to any person or corporation which is or may be liable for all or any portion of the charges, including insurance companies, health care service plans, workers' compensation carriers, adjusters or attorneys, to the extent necessary to obtain reimbursement; Also to the patient's personal physician, referring physicians, or primary care physician. If over 18 years of age, please list any additional persons you would like your records released to _____

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ AND UNDERSTANDS ALL THE ABOVE, AND AS THE PATIENT, GUARANTOR, OR THE PATIENT'S RESPONSIBLE PARTY AGREES TO AND ACCEPTS THE TERMS.

Signature of Patient/Responsible Party Signature of Witness Date

Please turn this page over to the back.



**LIFETIME AUTHORIZATION STATEMENT
ASSIGNMENT OF BENEFITS FOR DIRECT PAYMENT**

Patient Name: _____ Date: _____

ASSIGNMENT AND LIEN FOR MEDICAL SERVICES RENDERED DUE TO AN ACCIDENT – RELATED TO AUTO, WORKER’S COMPENSATION OR OTHER

If I receive or become entitled to receive any monies from any source whatsoever for my injuries, either through a lawsuit, settlement of a lawsuit or claim, aware by a court or arbitrator(s), jury verdict or payment of insurance proceeds, I hereby assign and agree to pay said funds to:

**Active Performance Care
6817 Southpoint Parkway Ste. 303
Jacksonville, FL 32216**

for the amount of any outstanding amounts then owed by me to Active Performance Care for medical services before any other fees, costs or expenses are disbursed from any said funds. I further agree that the fee for the services to be performed by Active Performance Care shall constitute a lien on any claim or lawsuit I may have as a result to my injuries and any settlement, aware, jury verdict or insurance process that I receive or become entitled to receive as a result of my injuries.

This Assignment and Lien shall be placed in my chart and a copy thereof shall constitute actual notice to my attorney, or any other person, that my medical bills to Active Performance Care shall be paid first from the proceeds of any such lawsuit, settlement, award, jury verdict or insurance. This authorization cannot be modified unless it is in writing and signed by both parties.

I understand that I remain personally responsible for the payment of all fees owed by me to Active Performance Care and that notwithstanding the Assignment and Lien, Active Performance Care is not required to look to any other person or entity for payment.

I have given authorization to Active Performance Care to forward a copy of this document to my attorney. This Assignment and Lien shall be effective regardless of whether it is countersigned by any such attorney.

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ AND UNDERSTANDS ALL THE ABOVE, AND AS THE PATIENT, GUARANTOR, OR THE PATIENT’S RESPONSIBLE PARTY AGREES TO AND ACCEPTS THE TERMS.

Signature of Patient/Responsible Party Signature of Witness Date

**REFUSAL TO SIGN LIFETIME AUTHORIZATION STATEMENT
ASSIGNMENT OF BENEFITS FOR DIRECT PAYMENT**

I, the above named, have been presented with the Lifetime Authorization Statement/Assignment of Benefits for Direct Payment Form and have refused to sign. In doing so, I am assuming full responsibility for all charges incurred during my evaluation and treatment at Active Performance Care. I understand that these charges are due in full at the time of service. Should you refuse this option, we have no other choice than to cancel your appointment.

Signature of Patient/Responsible Party Signature of Witness Date



CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

I (we) hereby request and consent to the performance of chiropractic adjustment and other chiropractic procedures on me or _____ by Jeffrey D. Lipp, D.C. and /or other licensed doctors of chiropractic who may be employed by or engaged in practice at Active Performance Care.

I understand that the practice of neither chiropractic nor medicine is an exact science and that my care may involve the making of judgments based upon the facts known to the doctor at the time, that it is not reasonable to expect the doctor to be able to anticipate or explain all risks and complications; that an undesirable result does not necessarily indicate an error in judgment; that no guarantees as to results has been made to nor relied upon by me and I wish to rely on the doctor to exercise judgment during the course of the procedure which he/she feels at the time, based upon the facts then known, is in my best interest.

I also understand the incidence of complications associated with chiropractic service is very low, anyone undergoing manipulative procedures should know the possible hazards and complications which may be encountered or result. These include, but are not limited to, fractures, disc injuries, strokes, dislocations, sprains, and those, which relate to physical aberrations unknown or reasonably undetectable by the doctor.

I have read or have had read to me, the above consent and by signing below, agree to the named procedures.

Patient/Legal Guardian's Printed Name: _____

Patient/Legal Guardian's Signature: _____ Date: _____

Relationship or authority if not signed by patient: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

(You may refuse to sign this acknowledgement.)

I, _____, have received a copy of this office's Notice of Privacy Practices.
Print Patient/Legal Guardian's Printed Name here

Patient/Legal Guardian's Signature: _____ Date: _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please specify)



NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION, SO PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This notice takes effect April 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditations, certifications, licensing, or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up medical supplies, nutritional supplements, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you \$1.00 for each page, \$0 per hour of staff time to locate and copy your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our structure.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12 month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing). Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Electronic Notice: If you receive this Notice on our website or by electronic mail (email), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact officer: Dr. Jeffrey D. Lipp
Telephone: 904-296-0202
Fax: 904-296-0505
Email: drlipp@activeperformancecare.com
Address: 6817 Southpoint Pkwy., Ste. 303
Jacksonville, FL 32216