Wolstein Chiropractic & Sports Injury Center
Dr. Karen Wolstein, D.C, M.S.
32976 US Hwy 19 N. Plam Harbor, FL. 34684
P: 727-787-6677 F: 727-787-1177

Date of Injury: _____

A. Patient Information

Name: _____ D.O.B: _____
Today's Date: _____ Home/Cell Phone: _____
Address: _____
City: _____ State: _____ Zip Code: _____
E-mail: _____
Sex: Male☐ Female☐ SS#: _____ ☐ Married☐ Widowed☐ Single☐ Divorced
Employer/School: _____ Occupation: _____
Address: _____ Phone: _____
Duties/Activities (bending, squatting, stretching, sitting, lifting, etc) _____
_____
_____.
Emergency Contact: _____ Phone: _____
Primary Care Physician: _____ Phone: _____

Parent or Legal Guardian Informaiton (if applicable)

Mother's Full Name: _____ Father's Full Name: _____
If not the parent/legal guardian, please explain you relationship to patient: _____
_____.

B. Motor Vehicle Accident Information:

Vehicle Insurance Company: _____
Claim #: _____ Policy #: _____
Date of Injury: _____
Claim Address: _____
Adjuster Name: _____ Phone: _____
Were you : Driver ___ Front Passenger ___ Back Seat Left ___ Back Seat Right ___
Did you have on your seatbelt? Yes ___ No ___
Did you strike your head against the vehicle? Yes ___ No ___
Did loose consciousness? Yes ___ No ___

C. Health Insuranc Information:

Insurance Company: _____
Insured's Name: _____ D.O.B: _____ SS#: _____
Insured's address (if different from above) _____
City: _____ State: _____ Zip Code: _____
Member ID #: _____ Group #: _____
Insurance Address : _____
City: _____ FL: _____ Zip: _____

D. Do you have secondary insurance?

If yes, please provide name: _____

Patient/Guardian Name(print): _____
Patient/Guardian Name(sign): _____
Date: _____

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D. Was this accident?

Auto ___ Motorcycle ___ Pedestrian ___ Bike ___ Other: ___
Describe how accident happened in detail: _____

_____
_____
_____
_____
_____
_____

Damage to car:

_____
_____
_____
_____
_____

Ambulance? Yes ___ No ___

Following the accident, did you go to the hospital? Yes ___ No ___
If you went to the hospital, were you admitted for stay? Yes ___ No ___ If so, how long? _____
Name of the hospital: _____
Please check which procedures were done at the hospital:
X-RAYS ___ CAT SCAN ___ PROCEDURES ___ MEDICATION PRESCRIPTIONS ___
SURGERY ___ STICHES ___ OTHER ___
Please indicate doctors you have seen regarding this medical condition and type of care they have provided. If none, please skip this section:

1. Doctor: _____ Specialty: _____ Date seen: _____
   Treatment: _____
2. Doctor: _____ Specialty: _____ Date seen: _____
   Treatment: _____
3. Doctor: _____ Specialty: _____ Date seen: _____
   Treatment: _____

Did the treatment(s) help? Explain what helped or did not help:

_____
_____
_____
_____

The above information is true to the best of my knowledge. I authorize my insurance benifits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Wolstein Chiropractic & Sports Injury Center, or my insurance company to release information required to process my claims.

Patient/Guardian Name(print): _____
Patient/Guardian Name(sign): _____
Date: _____

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E. Prior accident(s) information, if applicable:

Auto ___ Motorcycle ___ Pedestrian ___ Bike ___ Other: ___
Describe any injuries incurred: _____

F. Past Medical History

___ Diabetes	___ High Blood Pressure	___ Heart Disease
___ Asthma	___ Bronchitis/Emphysema	___ Seizure History
___ Hypo/Hyper Thyroid	___ Rheumatoid Arthritis	___ Cancer: Type _____
___ Ulcers	___ Hepatitis	___ Heart Attack
___ Blood Clots	___ HIV/AIDS	___ Other: _____

G. Past Surgical History

List any past surgeries you had: _____

H. Current Medications: List all medications you are taking NOW

Medication	*Doseage*	*Frequency*	*Reason*

Are you allergic to any medications? Yes ___ No ___
If yes, please list: _____

Patient/Guardian Name(print): _____
Patient/Guardian Name(sign): _____
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I. Social History

Do you smoke tobacco? Y___ N ___ How much/packs per day? _____ How long/years? _____
Do you drink alcohol? Y ___ N ___ How many drinks per day? _____ How long/years? _____
Do you use illegal drugs? Y ___ N ___
these may interact with medication(s) we prescribe so we must know
Have you had a history of alcohol abuse? Yes ___ No ___ drug abuse? Yes ___ No ___
Has anyone in your family had a history of alcoholism and/or drug abuse? Yes ___ No ___
Has anyone in your family had an adverse reaction to anesthesia? Yes ___ No ___

Do you have any problems related to the following?

Neurological	*Gastrointestinal*	*Respiratory*	*Hematology/Lymphatic*
Tremors	Abdominal Pain	Frequent Cough	Blood Clots
Dizzy Spells	Nausea/Vomiting	Shortness of breath	Easy Bleeder
Cardiovascular	*Musculoskeletal*	*Psychological*	*Genitourinary*
Chest Pain	Joint Pain	Depression	Urine Retention
High B.P.	Muscle Aches	Bi Polar Disorder	Bladder Control Loss
Heart Failure	Fibromyalgia	Schizophrenia	UTI

Other medical conditions not already mentioned: _____
_____
_____
_____

J. Pain Survey

Please check any of the following that pertain to your pain(s)

1. Neck Pain ___
Ache ___ Burning ___ Sharp ___ Tightness ___ Other _____
Does pain travel to left arm? ___ right arm? ___
Do you have pins & needles in your left arm? ___ right arm? ___
Do you have numbness in your left arm? ___ right arm? ___
Do you have previous injuries to your left neck? ___ right neck? ___

2. Upper Back
Ache ___ Burning ___ Sharp ___ Tightness ___ Other _____

3. Mid Back Pain
Ache ___ Burning ___ Sharp ___ Tightness ___ Other _____

4. Low Back Pain
Ache ___ Burning ___ Sharp ___ Tightness ___ Other _____

Does the pain travel to either buttock or leg? left leg / buttock ___ right leg / buttock ___
Do you have pins & needles in your buttock or leg? left leg / buttock ___ right leg / buttock ___
Do you have numbness in you buttock or leg? left leg / buttock ___ right leg / buttock ___
Do you have any previous injuries to your low back? right side ___ left side ___

Patient/Guardian Name(print): _____
Patient/Guardian Name(sign): _____
Date: _____

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J. Pain Survey Continued:

Please check any of the following that pertain to your pain(s)

5. Headaches Yes ___ No ___

Location: Temporal ___ Front of head ___ Back of head ___ All of head ___

Describe headache: Dull ___ Tension/Pressure ___ Sharp ___ Other _____

Frequency of headache: Rarely ___ Sometime ___ Every day ___ Constant ___

6. Do you have any of the following:

Dizziness ___ Change of vision ___ Passing out ___ Nausea/Vomiting ___

Additional symptoms: _____

7. Joint Pains:

Shoulders: right ___/left___ Elbows: right___/left___ Wrists: right ___/left ___ Fingers ___

Hips: right___/left___ Knees: right___/left___ Ankles: right___/left___ Toes ___

8. Jaw Pain: Right or Left:

Popping ___ Clicking ___ Stiff/Tight ___ Spasmodic ___

9. Additional area(s): _____

Ache ___ Burning ___ Sharp ___ Other _____

Describe the pain of eache area: Radiating, Sharp, Dull, Tight, Ache, Spasmodic, etc.)

_____

_____

_____

10. Does anything lessen your pain? Yes ___ No ___

Please explain: _____

11. Does anything worsen your pain? Yes ___ No ___

Please explain: _____

12. Additional comments: _____

_____

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Wolstein Chiropractic & Sports Injury Center, or insurance company, to release information required to process my claims.

Patient/Guardian Name(print): _____

Patient/Guardian Name(sign): _____

Date: _____

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PATIENT/PHYSICIAN AGREEMENT

Failure to follow physician orders:

"Physician Orders" are meant to improve and/or resolve the patient's medcal condition and/or symptoms. The patient is expected to follow orders given. In the event the patient does not follow given orders, the patient may be dischharged from the treating physician care and /or facility, from any injury or illness claim resulting from the patient's failure to follow orders. Not following orders given can include but not limited to missing/postponing appointments or refusal of making scheduled apoointments. I grant consent to Wolstein Chiropractic & Sports Injury Center to use and disclose my potected health information for the purposes of diagnosing or providing treatment and conducting surgical operations. I understand that the diagnosis and treatment of my, by Wolstein Chiropractic & Sports Injury Center, may be conditioned upon my consent, as evidence by my signature on this document.
I have read, understand and agree to the above.

Patient/Guardian Signature: _____ **Date:** _____

Prescription Refills:

Please don't wait until you run out of medicine to call for a refill. In fact, call at least 2 days ahead to protect yourself. Your doctor must review your medical file before remewing a prescription. Please do not call for refills after hours or on weekends when records are unavailable. It can take up to 48 hours after you call before the doctor can review your file and call in prescriptions. The files are reviewed and presscriptions are called to pharmacies at the end of the office hours, after all patients have been seen. By law, doctors cannot order certain narcotics over the phone; a written prescription is required in those cases.
I have read, understand and agree with the above.

Patient/Guardian Signature: _____ **Date:** _____

Medical Records:

Your records are kept in strict confidence as part of our permanent file. We will release copies only if we have your written permission. We prefer to mail copies of records, but are willing to give them to you in person, if hand-carry time is critical. Please give us at least 48 hours notice prior to picking up records as it does take some time to get them together. My protected health information includes demographic information which is collected from me, created or received by my physician and or other health care provider, and my employer. This protected information relates to my past, present, and future physical and mental health ondition(s).
I have read, understand and agree with the above.

Patient/Guardian Signature: _____ **Date:** _____

Statement of finacially responsibility:

I, the undersigned, realize that all medical and surgical charges incurred by me or my dependent(s) are my financial responsibility. All court fees, attorney fees, and other fee(s) necessary to collect theis amount are payable buy me.
I have read, understand, and agree with the above.

Patient/Guardian Signature: _____ **Date:** _____

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PATIENT/PHYSICIAN AGREEMENT CONT

Confidentiality:

The physician will diagnose you illness according to your complaints, symptoms, test results, and medical history. In order to treat the patient appropriately, the patient understands and authorizes the treating physician and/or facility to obtain any and all medical records relating to the patient and to communicate with previous physicians by a method that can assist with the care of the patient.
I have read, understand, and agree with the above.

Patient/Guardian Signature: _____ Date: _____

Individual Patient Authorization:

Name the people and/or organization and their relationship to you that you authorize to use and/or disclose your personal health information:

_____

_____

_____

Irrevocable Medical Lein:

I hereby authorize any and all parties, including any insurance company and my attorney (if applicable), to pay directly to Wolstein Chiropractic & Sports Injury Center sums as may be due and owed for medical services rendered to me. Such sums may be withheld from any settlement, judgement, or verdict as may be necessary to adequately protect Wolstein Chiropractic & Sports Injury Center. If applicable, I also authorize my attorney to release any and all information without limitation regarding any legal proceedings, judgements, or settlements that will aide in the recovery of Wolstein Chiropractic & Sports Injury Center upaid sum(s).

I fully understand that I am directly and fully responsible to Wolstein Chiropractic & Sports Injury Center for all medical bills incurred by me, for services rendered, in consideration of awaiting payment. I further understand that such payment is not contingent on any settlement, judgement, or verdict by which I may eventuallu recover said fee(s).

I hereby give my authorization to Wolstein Chiropractic & Sports Injury Centr to record a Uniform Commercial Code Form (UCC-1) to protect this medical lien and to send my unpaid sum to the Tortfeasor.
I have read, understand, and agree with the above.

Patient/Guardian Signature: _____ **Date:** _____

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NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used/disclosed and how you can get access to this information. Please review this carefully.

At Wolstein Chiropractic & Sports Injury Center, we have always kept your health information secure and confidential. The Health Insurance Portability & Accountability Act that requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice. The law permits us to use or disclose your health information to those involved in your treatment. For example, reviews of your file by a specialist doctor whom we may involve in your care. We may use or dosclose your health information for payment of you services. For example, we may send a report of your progress to your insurance company.We may use or disclose your health information for our normanl healthcare operations. For example, one of our staff will put your personal information into our computer system. We may use your personal information to contact you. For example, we may send you newsletters or other information. We may also want to call and remind you about upcoming appointments with us. If you don't answer we may leave this information on your voicemail or with another person that answers the call. We may release some or all of your health information when required by law. If this practice is sold, your information will become the property of the new owner.

Except as described above, this practice will not use/disclose your health information withour your prior written authorization. You may request in writing that we do not use/disclose your health information as described above. We will let you know if we can fulfill that written request.

You have the right to transfer copies of your health information to another practice. We will mail, fax, or email your files for you. You have the right to receive a copy of your health infromation, with a few exceptions. Please provide us with a written request regarding the information you want to have copied. If necessary, we may charge you a resonable fee for these copies.

You have the right to amend your health information. Please provide a written request to make these changes. If you wish to include a statement in your file, please provide it to us in writing. We may or may not make the changes you request but will include your statement in your personal file. If we agree to amend or change your information, we will neither move nor alter earlier documents, but we will add the new information.

You have the right to receive a copy of this notice at any time upon request.

If we change any details of this notice, we will notify you in writing.

You may file a complaint with the Department of Health and Human Services at 200 Independence Avenue SW, Room 509F, Washington, D.C. 20201. You will not be retaliated against for filing a complaint.

Acknowledgement: I have read, understand, and agree with the above Notice of Privacy Practice.

Patient/Guardian Name(print): _____

Patient/Guardian Name(sign): _____

Date: _____

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.**

_____

_____

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:

Patient Name (print):	Patient Name (sign):	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(14) and (15), 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)*:

DR. KAREN J. WOLSTEIN DC. MS		
Physician Name (print):	Physician Name (Sign):	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.

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ASSIGNMENT OF INSURANCE BENEFITS, LIEN, RELEASE & DEMAND

Insurer and Patient please read the following in its entirety carefully!

I, the undersigned patient/insured, knowingly, voluntarily and intentially irerevocably assign the rights and benefits of my automobile Insurance, known as Personal Injury Protection (herein after PIP), Unisured Motorist, and Medical Payments policy of insurance to the above health care provider. I understand it is the intention of the provider to accept this assignment of benefits in lieu of demanding payment at the time of service. I understand this document will allow the provider to file suit against an insurer for payment of the insurance benefits or an explanation of benefits and to seek 627.428 damages from the insurer. This assignment of benifits includes transportation, medications, supplies, overdue interest and any potential claim for common law or statutory bad faith/unfair claims handling. If the insurer disputes the validity of this assignment of benefits then the insurer is instructed to notify the provider in writing within five days of receipt of this document. Failure to inform the provider shall result in a waiver by the insurer to contest the validity of this document. The undersigned directs the insurer to pay the health care provider the maximum amount directly without any reduction and without including the patient's name on the check. To the extent the PIP insurer contends there is a material misrepresentation on the application for insurance resulting in the policy of insurance is declared voided, rescinded, or canceled, I as the named insured under said policy of insurance, hereby assign the right to receive the premiums paid for my PIP insurance to this provider and to file suit for recovery of the premiums. The insurer is directed to issure such a refund check payable to this provider only. Should the medical bills not exceed the premium refund, then the provider is directied to mail the patient/named insured a check whcih represents the difference between te medical bills and the premums paid.

LEIN: I, the undersigned patient guarantee full payment to Wolstein Chiropractic & Sports Injury Center, LLC. and agree that I will remain personally responsible for unpaid charges as a result of any deductible, co-payment, and treatment after benefits are exhausted and/or for any other treatment/ service that remain unpaid. Furthermore, I grant Wolstein Chiropractic & Sports Injury LLC. a lien against any recovery, which I may have against any tortfeasor, responsibe party, or any responsible insurance carrier. I direct my attorney to withhold any funds I receive from any settlement to pay for any outstanding balance to Wolstein Chiropractic & Sports Injury Center LLC. I agree to and instruct my attorney to promptly advise Wolstein Chiropractic & Sports Injury Center LLC., of any settlement as a result of the injuries sustained in the _____ (DATE) motor vehicle accident, slip-n-fall, or motorcycle accident. Additionally I agree and instruct my attorney that I will not accept any settlement check until the remaining balcance is resolved with Wolstein Chiropractic & Sports Injury Center LLC..

DIPUTES: The insurer is drected by the provider and the undersigned to not issue any checks or drafts in partial setlement of a claim that contain or are accompanied by language releasing the insurer or it's insured patient from liability unless there has been a prior written settlement agreed to by the health provider (specifically the office manager) and the insurer as to the amount payable under the insurance policy. The insured and provider hereby contest and objects to any reductions or partial payments. Any partial or reduced payment, regardless or the accompanying language, isssued by the insurer and deposited by the provider shall be done so under protest, at the risk of the insurer, and the deposit shall not be deemed a waiver, accord, satisfaction, discharge, settlement, or agreement by the provider to accept a reduced amount as payment in full. The insurer is hereby placed on notice that this provider reserves the right to seek the full amount of the bill submitted. If the PIP insurer states it can pay claims at 200% of the Medicare Fee Schedule or any other fee schedule contained within Fla. Stat. 627.736 (2018), the the insurer is instructed & directed to provide this provider with a copy of the policy of insurance within 10 days. Any effort by the insurer to pay a disputed debt as full satisfaction must be mailed to the above, after speaking with the office/billing manager and mailed to the attention of the office/billing manager. See Fla. Stat. 673.3111.

RELEASE OF INFORMATION: I hereby authorize this provider to: furnish an insurer, an insurer's intermediary, the pateint's other medical providers, and the patients attorney via mail, fax, or email, with any and all informaton that may me containeed in the medical records; and for my insurance carrier to send insurance coverage information (declaration sheet & policy of insurance) in writing and telephonically to the above-named provider; request from any insurer all explanation of benefits (EOBs) for all provier and non-redacted PIP payout sheets; obtain any wrtten and verbal statements the patient or anyone else provided to the insurer; obtain copies of the entire claim file and all medical records, including but not limited to, documents, reports, scans notes bills, opinions, X-rays, IMEs, and MRIs, from any other medical provider or any insurer. The provider is permitted to produce my medical records to its attorney in connection with any pending lawsuits. The insurer is directed to keep the patien't medical record from this provider private and condidential. The insurer is not authorized to provide these medical records to anyone without the patient's and the provider's prior express written permission. **PLEASE NOTE: The insurer is not authoried to release protected health information (PHI) to third party vendors that schedule independent medical eaminations or independent medical examination physicians.**

DEMAND: Demand is hereby made for the insurer to pay all bills within 30 days without reduction and to mail the latest non-reducted PIP payout sheet ad the insurance coverage declaration sheet, and the insurance policy to the above provider within 15 days, as well as notify the provider pursuant to F.S. 627.736 (6-F) when benefits have been exhausted. The insurer is directied to pay the bill in the order they are received. However, if a bill from this provider and a claim from anyone else is received by the insurer on the same day, the insurer is directied to not apply this provider's bill to the deductible. If a bill from this provider and a claim from anyone else is received by the insurer, on the same day, the insurer is directed to pay this provider first before the policy is exhausted. The insurer is instructied to inform, in writing, the provider of any dispute.

CAUTION: **Please read before signing. If you do not completely understand this document, please ask us to explain it to you. If you sign below we will assume you understand and agree to the above. I certify that I have read and agree to all of the above and was not soliited or promised anything in exchange for receiving health care. I agree that the prices for the medical care is reasonable.**

Patient/Guardian Name(print): _____

Patient/Guardian Name(sign): _____

Date: _____

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AUTHORIZATION TO RELEASE RECORDS:

ATTENTION MEDICAL RECORDS DEPARTMENT

Physician: _____

Medical Facility: _____

Phone: _____

Fax: _____

Please release all records, radiology/diagnostic reports and any results pertaining to any and all treatment rendered to the following patient.

Patient Name: _____

DOB: _____ /_____ /_____

Social Security Number: _____ - _____ - _____

Thank You,

Patient/Guardian Name(print): _____

Patient/Guardian Name(sign): _____

Date: _____

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OFFICE POLICIES

Insurer and Patient please carefully read the following in its entirety!

The following is an explanation of our clinic policies. We believe that a clear definition will allow us both to concentrate on the most important issues: REGAINING AND MAINTING YOUR HEALTH.

Appointments & Scheduling:

In order to better serve our patients we ask that you call if you are unable to make your appointment or if you will be late. Your appointment time is reserved for you. If you fail to notify our office, it leaves a time slot open that could be used to help another patient. If you are scheduled for a massage and are more than 5 minutes late, you may ot be able to get your massage. This will depend on the scheduling of other patients. Please try to arrive earlier than your scheduled time. To schedule, cancel, or change appointments, you must call the office at: 727-787-6677.

If you are unable to keep you appointment, please call. Late arrival may necessitate rescheduling your appointment or missing out on therapies. If a patient fails to keep an appointment and does not call within 24 hours to cancel, a $50 fee will be applied to their bill.

Cell Phone Policy:

We ask that while in the office you refrain from using your cell phone. If a call is important and you "must" take it, please understand that the doctor will bypass you for the next ready patient, so that we don't delay others. You will then be the next patient to be seen by the doctor. We also ask that you wait to place your scheduled appointment in your phone until you are away from the reception desk. This will allow others to check out and this will comply with HIPPA standards.

Health Insurance Policy:

Today most insurance policies do cover chiropractic care but may not cover all treatments offered in our office. We will be happy to file your primary insurance claim and do everything we can to ensure that you receive proper reimbursement. We cannot take responsibility for what your health insurance will or will not cover. If your policy has a deductible, then we suggest you pay this amount at the onset of your care. Payments for services are neither implied nor agreed to by our office. *Our office takes no responsibility for non-payment by insurance companies for services rendered.*

I agree that my account with Wolstein Chiropractic & Sports Injury Center is my responsibility. I agree to standby any balance that has gone unpaid over 60 days. If I default on my account, I agree to pay all costs of collections, including collection agency fees and /or reasonable attorney's fees. Furthermore, I understand that these prodedures and fees are subject to change without prior notice. I understand and agree to the conditions of this policy.

Patient/Guardian Name(print): _____

Patient/Guardian Name(sign): _____

Date: _____

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RELEASE/WAIVER FORM:

I accept full responsibility for my use of any and all apparatus, appliances, facility privileges, or service whatsoever owned by Wolstein Chiropractic & Sports Injury Center, it's shareholders, directors, employees, representatives or agents. I hold them harmless for any and all loss, claim, injury, damage or liability sustained or incurred by me resulting there from.

I fully understand and agree that I am engaging in physical exercise and the use of exercise equipment owned by Wolstein Chiropractic & Sports Injury Centers, and training & instruction, which could cause injury.

I am voluntarily participating in these activities and assume all risks that might result. I hereby agree to waive any claim or rights I might otherwise have to sue the facility, it's employees or agents for injury on account of these activities. I have carefully read this waiver/release and fully understand it is a release of liability.

Patient/Guardian Name(print): _____

Patient/Guardian Name(sign): _____

Date: _____