EMAIL ADDRESS: _____

PATIENT INFORMATION FORM

First Name _____ M.I. _____ Last Name _____ Phone ( )_____

Address _____ City _____ State _____ Zip _____

Age _____ Sex _____ Birth Date ____/____/____ Marital Status (S M W D) Spouse's Name _____

Social Security # _____ Occupation _____ Employer _____

Work Phone ( )_____ Work Address _____ City _____ State ____ Zip _____

Referred By _____ Person Responsible For This Account _____

HEALTH INSURANCE INFORMATION

Name Of Insured _____ Relation To Patient _____ Insured's SSN # _____

Insurance Company _____ Group # _____ Policy # _____

Phone ( )_____ Address _____ City _____ State ___ Zip ____

SECONDARY INSURANCE INFORMATION

Name Of Insured _____ Relation To Patient _____ Insureds SSN # _____

Insurance Company _____ Group # _____ Policy # _____

Phone ( )_____ Address _____ City _____ State ____ Zip _____

AUTOMOBILE INSURANCE INFORMATION

Name Of Insured _____ Relation To Patient _____ Insureds SSN # _____

Insurance Company _____ Group # _____ Policy # _____

Phone ( )_____ Address _____ City _____ State ____ Zip _____

ATTORNEY INFORMATION

Attorney Name _____ Phone ( )_____

Address _____ City _____ State _____ Zip _____

What is your major complaint? _____

Is this condition due to an: A) Auto Accident B) Work Injury C) Other Accident D) Unknown Cause E) Illness

Are the symptoms: A) Improving B) Getting Worse C) About The Same D) Intermittent (come & go) **Date Symptoms Appeared** _____

Circle activities which aggravates your condition: A) Standing B) Walking C) Sitting D) Lying E) Bending F) Lifting G) Twisting H) Coughing

Have you had these symptoms before? (YES / NO) If so, when? _____

Have you seen another doctor for this condition? A) M.D. B) Chiropractor C) Osteopath D) Acupuncturist E) Dentist F) Podiatrist G)_____

Name Of the Doctor _____ Phone ( )_____ Date Consulted _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I authorize payment from my insurance carrier directly to this office with the understanding that all moneys will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I understand that if I suspend or terminate my care and treatment, and fees for professional services rendered me will be immediately due and payable. In the event of default I promise to pay legal interest on the indebtedness together with such collection costs and reasonable attorney fees as may be required to effect collection.

Patient's Signature _____ Date _____

SYMPTOM SURVEY

PATIENT NAME _____ DATE _____

Circle only what applies to this injury, illness or accident.

GENERAL SYMPTOMS

A) Nervousness B) Irritability C) Fatigue D) Depression
E) Loss Of Sleep F) Tension G) PMS H) Jaw Pain

HEAD

A) Headaches 1) Mild 2) Moderate 3) Severe
How Often (1 2 3 4 5 6) Per (Day / Week / Month)
Are They 1) Sharp 2) Dull
Are They 1) Constant 2) Intermittent
Located 1) Back Of Head 2) Forehead 3) Temple
4) Right Side 5) Left Side 6) Behind Eyes
B) Light headed C) Memory Loss D) Fainting E) Blurred Vision
F) Double Vision G) Sensitive To Light H) Loss Of Balance
I) Hearing Loss J) Ringing In Ears

NECK

A) Pain 1) Left 2) Right 3) Both
Pain Level 1) Mild 2) Moderate 3) Severe
Pain Increased by: 1) Forward Movement 2) Backward Movement
3) Rotate Head Left 4) Rotate Head Right
5) Bend Neck Left 6) Bend Neck Right
B) Stiffness C) Muscle Spasms D) Grinding / Grating

SHOULDERS

A) Pain In Joint	1) Left	2) Right	3) Both
B) Pain Across Shoulders	1) Left	2) Right	3) Both
C) Limitation Of Movement	1) Left	2) Right	3) Both
D) Tension	1) Left	2) Right	3) Both

ARMS

A) Pain In Upper Arm	1) Left	2) Right	3) Both
B) Pain In Elbow	1) Left	2) Right	3) Both
C) Pain In Forearm	1) Left	2) Right	3) Both
D) Pins & Needles (arm)	1) Left	2) Right	3) Both
E) Pins & Needles (forearm)	1) Left	2) Right	3) Both
F) Numbness In Arm	1) Left	2) Right	3) Both
G) Numbness In Forearm	1) Left	2) Right	3) Both

HANDS

A) Pain In Wrist	1) Left	2) Right	3) Both
B) Pain In Hand	1) Left	2) Right	3) Both
C) Pins & Needles (hand)	1) Left	2) Right	3) Both
D) Numbness	1) Left	2) Right	3) Both

MID BACK

A) Pain	1) Left	2) Right	3) Both
Pain Level	1) Mild	2) Moderate	3) Severe
Pain Type	1) Sharp/Stabbing	2) Dull Ache	
B) Muscle Spasms in	1) Left	2) Right	3) Both

CHEST

A) Deep Chest Pain	1) Left	2) Right	3) Both
Pain Level	1) Mild	2) Moderate	3) Severe
B) Pain Around Ribs	1) Left	2) Right	3) Both
C) Shortness Of Breath			
D) Irregular Heartbeat			

ABDOMINAL SYMPTOMS

A) Pain 1) Left 2) Right 3) Both
B) Nervous Stomach C) Nausea D) Gas E) Constipatio
F) Diarrhea G) Heartburn H) Indigestion I) Loss Of Appetite

LOW BACK

A) Upper Lumbar Pain	1) Left	2) Right	3) Both
B) Lower Lumbar Pain	1) Left	2) Right	3) Both
C) Sacro-Iliac Pain	1) Left	2) Right	3) Both
D) Muscle Spasms	1) Left	2) Right	3) Both
Low Back Pain Level	1) Mild	2) Moderate	3) Severe

HIPS AND LEGS

A) Pain In Buttocks	1) Left	2) Right	3) Both
Pain Level	1) Mild	2) Moderate	3) Severe
B) Pain In Hip Joint	1) Left	2) Right	3) Both
Pain Level	1) Mild	2) Moderate	3) Severe
C) Pain Down Leg	1) Left	2) Right	3) Both
Location	1) Front	2) Back	3) Side
Pain Radiates to	1) Knee	2) Calf	3) Foot
D) Numbness Down Leg	1) Left	2) Right	3) Both
Location	1) Front	2) Back	3) Side
E) Pins & Needles (legs)	1) Left	2) Right	3) Both
Location	1) Front	2) Back	3) Side
F) Knee Pain	1) Left	2) Right	3) Both
G) Leg Cramps	1) Left	2) Right	3) Both

FEET

A) Ankle Pain	1) Left	2) Right	3) Both
B) Swollen Ankle	1) Left	2) Right	3) Both
C) Foot Pain	1) Left	2) Right	3) Both
D) Numbness of Feet	1) Left	2) Right	3) Both
E) Swollen Feet	1) Left	2) Right	3) Both
F) Cramps	1) Left	2) Right	3) Both

The above is true and correct to the best of my knowledge.

Patient Signature _____

QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name _____ Date _____

Please read carefully:

Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

Example:

Headache Neck Low Back

No pain 0 1 (2) 3 4 (5) 6 7 (8) 9 10 worst possible pain

---

1 – What is your pain RIGHT NOW?

No pain 0 1 2 3 4 5 6 7 8 9 10 worst possible pain

2 – What is your TYPICAL or AVERAGE pain?

No pain 0 1 2 3 4 5 6 7 8 9 10 worst possible pain

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

No pain 0 1 2 3 4 5 6 7 8 9 10 worst possible pain

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

No pain 0 1 2 3 4 5 6 7 8 9 10 worst possible pain

OTHER COMMENTS:

_____

_____

_____
Examiner

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

AUTHORIZATION FOR RELEASE OF RECORDS INCLUDING PROTECTED HEALTH INFORMATION

IMPORTANT: Do not sign this form unless you have read it carefully and understand all its provisions. Eligibility for treatment will not be conditioned upon providing or refusing to provide this authorization.

Please **REQUEST** Medical Information **FROM**:

_____
Name of Health Provider

_____
Name of Medical Office/Hospital

_____
Street Address

_____
City, State and Zip Code

Please **SEND** Medical Information **TO**:

MENDYK CHIROPRACTIC, INC.
Name of Person or Entity to Receive Information

DERICK J. LAJOM, D.C.
Title (Physician, Therapist, Attorney

22635 ALESSANDRO BLVD STE 400 UNIT D
Street Address

MORENO VALLEY, CA 92553
City, State and Zip Code

I hereby authorize _____ **to release and/or disclose the medical information as indicated below to the health care provider, entity, or person I have indicated above.**

Release and/or disclose records and information regarding:

_____ _____
Name of Patient (List Other Names Used) Date of Birth

_____ ( ) .
Address City State Zip Code Telephone Number

DURATION: This authorization shall become effective immediately and shall remain in effect until _____ (enter date) or for one year from the date of signature if no date entered.

REVOCATION: This authorization may be revoked in writing by the undersigned at any time prior to the release of information from the disclosing party. Written revocation will not affect any action taken in reliance on this authorization before the written revocation was received.

REDISCLOSURE: I understand that the requester may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless disclosure is specifically required or permitted by law.

Specify the records to be released and/or disclosed:

- ☐ **General Medical Information** (from_____ to _____)
- ☐ **Information Regarding Specific Injury or Treatment** (from _____ to _____)
- ☐ **X-ray's, MRI's CT scans, films and reports**
- ☐ **Laboratory Results**
- ☐ **Mental Health** (from _____ to _____)
- ☐ **Alcohol/Drug** (from _____ to _____)
- ☐ **HIV Test Results** (from _____ to _____)
- ☐ **Other (specify):** _____

_____ _____
Signature of Patient or Patient's Representative Date

_____ _____
Signature of Patient or Patient's Representative Date

_____ _____
Signature of Patient or Patient's Representative Date

I request that the health information released and/or disclosed pursuant to this authorization be used for the following purposes only: _____

A copy of this authorization is valid as an original.
I have the right to receive a copy of this authorization. The copy is for me to keep.

_____ _____ _____
Date Signature of Patient or Patient's Representative Indicate Relationship (if Signed by Other than Patient

FINANCIAL AGREEMENT

We would like to take a moment to welcome you to our office and assure you will be receiving the best care available.

In order to familiarize you with the financial policy of our office, I would like to explain how your medical bills will be handled. Charges for treatment in this office are due and payable at the time the service is performed. However, if this is inconvenient for you, we will be glad to set up a payment plan to assist you while your under current care at our office.

PAYMENT PLAN

_____ **CASH:** I agree to make a minimum monthly/ weekly payments of $_____. I agree to pay any outstanding balance within one week prior to the end of my program.

_____ **INSURANCE:** I understand that the terms of my insurance policy are between the insurance company and me. Should my insurance company deny any charges incurred, I will be personally responsible for payment for those services in full. I agree to pay my yearly deductible amount and $_____ as my co-payment portion per visit.

_____ **PERSONAL INJURY:** I agree to allow **MENDYK CHIROPRACTIC, INC.** to submit all charges incurred for this accident to my automobile medical payment policy. I further agree that if no insurance coverage is available of if I exhaust my benefits that I will be personally responsible to pay all charges incurred.

_____ **UNINSURED MOTORIST:** I understand that I am making a claim against my own auto insurance under the uninsured motorist portion of my policy and that this policy will not pay **MENDYK CHIROPRACTIC, INC.** directly. I agree to be personally responsible to pay charges incurred.

_____ **3rd PARTY CLAIM:** I understand that I am making a claim against a 3rd party insurance company and this policy does not reimburse the doctor directly for any services incurred as a result of my claim. I agree to be personally responsible to pay all charges incurred.

_____ **ATTORNEY LIEN:** I understand that **MENDYK CHIROPRACTIC, INC.** has agreed to carry the balance of any unpaid charges on a lien with my attorney. I further understand that if I change attorneys and do not notify the doctor or release my attorney prior to the settlement of my claim this agreement is void and I agree to pay the full balance due immediately.

_____ **MEDICARE:** I understand that Medicare will only pay for 12 office visits (24 if there is more than one location effected) per year. I understand that I will require X-RAY'S to properly diagnosis my condition but Medicare will not pay for them and I am responsible for the payment of them on the date that they are taken. Supports, vitamins, or any supplies are not covered by Medicare, therefore, I am responsible for any charges incurred for such items.

I further understand that if I suspend or terminate my care with this office, my balance will be immediately due and payable.

I have read and agree to the above:

Patient's Signature **Parents signature if the patient is a minor** **Date**

HIPAA HAPPENINGS

This notice describes how your health information may be used and how you can gain access to this information. Please review it carefully.

Our Promise To You our Valued Patient....

This is not meant to alarm you. Quite the opposite. We want to assure you that we take the new Federal (HIPAA-Health Insurance Portability and Accountability Act) laws seriously. These laws were written to protect the confidentiality of your health information. We trust you will never delay treatment in our offices because of fear that your personal health information might be unnecessarily disclosed to others outside our office.

Why A Privacy Policy Now?
The most significant variable that has motivated the Federal government to legally enforce the privacy of health information is the rapid evolution of the use of electronic technology in the administration of health care business. The government has appropriately sought to standardize and protect the electronic exchange of your health information. This has challenged us to review not only how your information is used within our computers but also with the Internet, phones fax machines and any device used to copy or transfer that data.

We want to advise you that we have developed policies and procedures for your practice to assure that your personal or health information will be shared only as required and only for the purpose of administering your case. Our office is subject to State and Federal laws regarding the confidentiality of your health information and we will assure adherence to those laws and we want you to understand our procedures and your rights as a valued patient.

Your health information will be communicated only for the purpose of obtaining payment for services and conducting health care business. Be assured that without your written permission, your health information will not be used for any other purpose.

How Your Health Information May Be Used To Provide Treatment
Within our office, your health information will be used to provide you the best care and services possible. This may include administrative and clinical procedures designed to optimize scheduling and coordination between you and all office personnel. In addition, we may share this information with referring physicians, clinical pathology laboratories or other health professionals providing you treatment.

To Obtain Payment
Your health information may be included with an invoice for the purpose of collecting payment for services provided to you in this office. We may do this with insurance forms filed for you by mail or electronically. We will make all effort to work with companies with a similar commitment to the security of your health information.

To Conduct Health Care Operations
Your health information may be used during performance evaluations of our staff. Some of our best teaching opportunities use clinical situations experienced by patient receiving care in our office. As a result, your health information may be included in the training programs for students, interns, associates, as well as business and clinical employees. It is also possible that your health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may reviewed during the routine process of certification, licensing or credentialing activities.

In Patient Reminders
Because we believe regular care is very important to your general health, we will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you to follow up on your care and inform you of treatment options or services that may be of interest to you or members of you family. These communications are an important part of our philosophy of partnering with our patients to be sure they receive the best care chiropractic can provide. They may include postcards, newsletters, flyers telephone or electronic reminders such as e-mail (*unless you tell us that you prefer not to receive reminders.*)

Public Health and National Security
We may be required to disclose to Federal officials or military authorities health information necessary to complete an investigation related to public health and or national security.

For Law Enforcement
As permitted or required by state of Federal law, we may disclose your health information to a proper a proper authorities for the purpose of law enforcement including under certain circumstances, if you are a victim of a crime or in order to report a suspected crime.

Family, Friends, and Caregivers
We may share your health information with those you tell us will be assisting you with your home hygiene, care, treatment or payment. We will be certain to obtain your permission prior to sharing you information. In the event of an emergency, were you unable to tell us what you want, we will use our very best judgment when sharing your health information with anyone participating in your care.

Medical Research
Advancing heath care knowledge often involves learning from the careful study of health histories or prior patients. Formal review and study of health histories as a part of a research study will happen only under the ethical guidance, requirements, and approval of an Institutional Review Board.

Authorization to Use or Disclose Health Information
Other than is stated above or where Federal, State of Local law required us, we will not disclose your health information other than with your written authorization. *You may revoke that authorization in writing at any time.*

Patient Rights
This law is careful to describe that you have the following rights related to your health information. Be assured that our office will make every effort to honor reasonable restriction preferences for our patients.

Confidential Communications
You have the right to request that we communicate with you in a specific way. You may request that we only communicate your health information privately with or without other family members present or through sealed mail communication. We will make all reasonable effort to honor your request.

Inspect and Copy Your Health Information
You have the right to read, review and copy your health information, including your complete chart, x-rays and billing records. If you would like a copy of your health information, please let us know. We may need to charge you a reasonable fee to duplicate and assemble your copy.

Amend Your Health Information
You have the right to ask us to update or modify your records if you believe your health information is incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe as completely as possible your reason for the request.

Your request may be denied if the health information record in question was not created by our office, is not part of our records, or if the records containing your health information have been requested sealed and or delivered to any authority for review.

Documentation of Health Information
You have the right to request from us a description of how and where your health information was used by our office for any reason other than for treatment or payment, or health care operations. Our documentation procedures will enable us to provide information on your health information usage from April 14, 2003 and forward. Please let us know in writing the time period for which you are interested. We will greatly appreciate you limiting your request to no more than six years at a time. We may need to charge you a reasonable fee for request.

Request a Paper Copy of this Notice
You have the right to request and obtain a copy of the Notice of Privacy Practices directly form our office at any time. Just let us know of your request. We are required by law to maintain the privacy of your health information and to provide to you and your representative this Notice of our Privacy Practices. We are required to practice the policies and procedures described in this notice but we do reserve the right to change the terms of our notice. Patients would be notified of any such changes.
You have the right to express concerns or complaints to us or the Secretary of Health and Human Services if you believe your privacy right have been compromised. We encourage you to express in writing, any concerns you may have regarding the privacy of your health information.

Patient Acknowledgement

Patient Name(s):

_____

_____

Thank you very much for taking time to review how we are carefully using your health information. If you have questions, pleas let us know. If not, we would appreciate your acknowledgement by signature that you have received, thoroughly and reviewed and understand this policy.

_____ Date _____
Patient Signature

Thank You For Your Trust and Confidence

MENDYK
CHIROPRACTIC, INC.

Informed Consent for Chiropractic Care

Kristian D. Mendyk, D.C
Graduate: Los Angeles College of Chiropractic

Member: CCA

Industrial Disability Evaluator

QME, State Appointed

M.U.A. Certification Program

Derick J. Lajom, D.C.
Graduate: Los Angeles College of Chiropractic

Member: ACA

Industrial Disability Evaluator

QME, State Appointed

When a patient seeks chiropractic health and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may affect the restoration and preservation of health. Health is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an adjustment. An adjustment is the specific application of forces to correct and or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

_____ _____ _____

Print Name Signature Date

Consent to evaluate and adjust a minor child:

I_____ being the parent or legal guardian of _____have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

Pregnancy Release:

This is to certify that the best of my knowledge I am not pregnant and the above doctor and his associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle_____

Signature_____ Date_____

Ramona Market Place
764 W. Ramona Expressway Suite A
Perris, CA 92571
Office (951) 943-1722
Fax (951) 943-3133

22635 Alessandro Boulevard
Suite. 400 Unit D
Moreno Valley, CA 92553
Office (951) 697-0246
Fax (951) 697-0176

MENDYK CHIROPRACTIC, INC.

Dr. Kristian D. Mendyk
Graduate: Los Angeles College of Chiropractic
Member: CCA
Industrial Disability Evaluator
QME, State Appointed
M.U.A. Certification Program

Dr. Derick J. Lajom
Graduate: Los Angeles College of Chiropractic
Member: ACA
Industrial Disability Evaluator
QME, State Appointed

ASSIGNMENT OF BENEFITS AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR PRIVATE AND GROUP ACCIDENT AND HEALTH INSURANCE

REGARDING OUR PATIENT: _____

YOUR INSURED'S NAME : _____

CLAIM OR GROUP NUMBER: _____

SS# OR ID# YOUR INSRD: _____

I hereby instruct and direct the _____ Insurance Company to pay by check made out and mailed directly to:

Mendyk Chiropractic, Inc.
1688 N. Perris Blvd., Ste. G-2
Perris, CA 92571

If the current policy prohibits the direct payment to doctor, then I hereby also instruct and direct you to make the check out to me and mail it as follows:

C/O Mendyk Chiropractic, Inc.
1688 N. Perris Blvd., Ste. G-2
Perris, CA 92571

For the professional or medical expense of benefits allowable, and otherwise payable to me under the current insurance policy as payment toward the total charges for professional services rendered. **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.** This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

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

Dated at _____ this _____ day of _____ 20 _____

_____ _____
Signature of Patient or Parent/Guardian Witness

_____ _____
Signature of Claimant (if other than Policy Holder) Witness

Ramona Market Place
764 W. Ramona Expressway Suite A
Perris, CA 92571
Office (951) 943-1722
Fax (951) 943-3133

22635 Alessandro Boulevard
Suite. 400 Unit D
Moreno Valley, CA 92553
Office (951) 697-0246
Fax (951) 697-0176

MENDYK
CHIROPRACTIC, INC.

Kristian D. Mendyk, D.C.
Graduate: Los Angeles College of Chiropractic
Member: CCA
Industrial Disability Evaluator
QME, State Appointed
M.U.A. Certification Program

Derick J. Lajom, D.C.
Graduate: Los Angeles College of Chiropractic
Member: ACA
Industrial Disability Evaluator
QME, State Appointed

CONSENT TO TREATMENT OF A MINOR

I (WE) BEING THE PARENT OR LEGAL GUARDIAN OF _____, A MINOR, THE AGE OF _____ DO HEREBY CONSENT, AUTHORIZE AND REQUEST MENDYK CHIROPRACTIC, INC. TO ADMINISTER SUCH TREATMENT AS DEEMED ADVISABLE, NECESSARY OR REQUESTED ON THE ABOVE MINOR.

I (WE) AGREE TO HOLD THE CLINIC FREE AND HARMLESS FROM ANY CLAIMS OR SUITS FOR DAMAGES OR COMPLICATIONS, WHICH MAY RESULT FROM SUCH TREATMENT.

_____

PARENT OR LEGAL GUARDIAN SIGNATURE

_____

TODAY'S DATE

_____

WITNESS

Ramona Market Place
764 W. Ramona Expressway Suite A
Perris, CA 92571
Office (951) 943-1722
Fax (951) 943-3133

22635 Alessandro Boulevard
Suite. 400 Unit D
Moreno Valley, CA 92553
Office (951) 697-0246
Fax (951) 697-0176