J. MICHAEL STOLLEY, D.C, C.Ad.
12122 SEMINOLE BLVD.
LARGO, FLORIDA 33778

INFORMED CONSENT

WHEN A PATIENT SEEKS CHIROPRACTIC HEALTH CARE AND WE ACCEPT A PATIENT FOR SUCH CARE, IT IS ESSENTIAL FOR BOTH TO BE WORKING TOWARDS THE SAME OBJECTIVE. A PATIENT, IN COMING TO THE DOCTOR OF CHIROPRACTIC, GIVES THE DOCTOR PERMISSION AND AUTHORITY TO CARE FOR THE PATIENT IN ACCORDANCE WITH CHIROPRACTIC TESTS, DIAGNOSIS AND ANALYSIS.

A CHIROPRACTIC ADJUSTMENT IS A SPECIFIC APPLICATION OF FORCES TO FACILITATE THE BODY'S CORRECTION OF VERTEBRAL SUBLUXATION. CHIROPRACTIC ADJUSTMENTS OR OTHER CLINICAL PROCEDURES ARE USUALLY BENEFICIAL AND SELDOM CAUSE ANY PROBLEM. IN RARE CASES, UNDERLYING PHYSICAL DEFECTS, DEFORMITIES OR PATHOLOGIES MAY RENDER THE PATIENT SUSCEPTIBLE TO INJURY. THE DOCTOR WILL NOT GIVE AN ADJUSTMENT OF HEALTH CARE IF HE IS AWARE THAT SUCH CARE MAY BE CONTRA-INDICATED. AGAIN, IT IS THE RESPONSIBILITY OF THE PATIENT TO MAKE IT KNOWN OR TO LEARN THROUGH HEALTH CARE PROCEDURES WHATEVER HE IS SUFFERING FROM: LATENT PHYSICAL DEFECTS, ILLNESS OR DEFORMITIES WHICH WOULD OTHERWISE NOT COME TO THE ATTENTION OF THE DOCTOR OF CHIROPRACTIC. THE PATIENT SHOULD LOOK TO THE CORRECT SPECIALISTS FOR THE PROPER DIAGNOSTIC AND CLINICAL PROCEDURES. WE DO NOT OFFER TO DIAGNOSE OR TREAT ANY DISEASE OR CONDITION OTHER THAN VERTEBRAL SUBLUXATION, A MISALIGNMENT OF ONE OR MORE VERTEBRA, WHICH RESULTS IN A LESSENING OF THE BODY'S INNATE ABILITY TO EXPRESS ITS MAXIMUM HEALTH POTENTIAL. HOWEVER, IF DURING THE COURSE OF A CHIROPRACTIC SPINAL EXAM, WE ENCOUNTER NON-CHIROPRACTIC OR UNUSUAL FINDINGS, WE WILL ADVISE YOU. WE WILL RECOMMEND THAT YOU SEEK THE SERVICES OF A HEALTH CARE PROVIDER WHO SPECIALIZES IN THAT AREA. WE DO NOT OFFER ADVICE REGARDING TREATMENT PRESCRIBED BY OTHERS. SOMETIMES, WHEN THERE IS AN EXTENSIVE HEALTH HISTORY, CHIROPRACTIC TREATMENT MAY CAUSE RETRACING/HEALING CRISIS.

THE TYPE OF TREATMENT PROVIDED IN THIS OFFIC, i.e.: SOFT TISSUE, MUSCLE BALANCING, TMJ AND CRANIAL ADJUSTING, ARE NOT COVERED BY MEDICARE AND MOST INSURANCES.

I UNDERSTAND THAT THIS OFFICE DOES NOT PARTICIPATE IN OR BILL MEDICARE AS WELL AS ANY HMO INSURANCES.

I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL INCURRED EXPENSES FOR TREATMENT.

PLEASE SIGN BELOW

I, _____, HAVE READ AND FULLY UNDERSTAND THE ABOVE STATEMENTS. I THEREFORE ACCEPT CHIROPRACTIC CARE ON THIS BASIS.

SIGNATURE_____DATE_____

J. MICHAEL STOLLEY, D.C.
12122 SEMINOLE BLVD.
LARGO, FLORIDA 33778

NOTICE OF PRIVACY PRACTICES

TO OUR PATIENTS:
THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU, AS A PATIENT OF THIS PRACTICE, MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR HEALTH INFORMATION. THIS IS REQUIRED BY THE PRIVACY REGULATIONS CREATED AS A RESULT OF THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPPAA).

OUR PRACTICE IS DEDICATED TO MAINTAINING THE PRIVACY OF YOUR HEALTH INFORMATION. WE ARE REQUIRED BY LAW TO MAINTAIN THE CONFIDENTIALLY OF YOUR HEALTH INFORMATION. WE REALIZE THAT THESE LAWS ARE COMPLICATED, BUT WE MUST PROVIDE YOU WITH THE FOLLOWING IMPORTANT INFORMATION REGARDING USE AND DISCLOSURE OF YOUR HEALTH INFORMATION IN CERTAIN SPECIAL CIRCUMSTANCES:

1. TO PUBLIC HEALTH AUTHORITIES AND HEALTH OVERSIGHT AGENCIES THAT ARE AUTHORIZED BY LAW TO COLLECT INFORMATION.
2. LAWSUITS AND SIMILAR PROCEEDINGS IN RESPONSE TO A COURT OR ADMINISTRATIVE ORDER.
3. IF REQUIRED TO DO SO BY A LAW ENFORCEMENT OFFICIAL.
4. WHEN NECESSARY TO REDUCE OR PREVENT A SERIOUS THREAT TO YOUR HEALTH AND SAFETY OR THE HEALTH AND SAFETY OF ANOTHER INDIVIDUAL OR THE PUBLIC. WE WILL ONLY MAKE DISCLOSURES TO A PERSON OR ORGANIZATION ABLE TO HELP PREVENT THE THREAT
5. IF YOU ARE A MEMBER OF U.S. OR FOREIGN MILITARY FORCES (INCLUDING VETERANS) AND IF REQUIRED BY THE APPROPRIATE AUTHORITIES
6. TO FEDERAL OFFICIALS FOR INTELLIGENCE AND NATIONAL SECURITY ACTIVITIES AUTHORIZED BY LAW
7. TO CORRECTIONAL INSTITUTIONS OR LAW ENFORCEMENT OFFICIALS IF YOU ARE AN INMATE OR UNDER THE CUSTODY OF A LAW ENFORCEMENT OFFICIAL
8. FOR WORKERS' COMPENSATION AND SIMILAR PROGRAMS

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION:

1. COMMUNICATIONS. YOU CAN REQUEST THAT OUR PRACTICE COMMUNICATE WITH YOU ABOUT YOUR HEALTH AND RELATED ISSUES IN A PARTICULAR MANNER OR AT A CERTAIN LOCATION. FOR INSTANCE, YOU MAY ASK THAT WE CONTACT YOU AT HOME, RATHER THAN WORK. WE WILL ACCOMMODATE REASONABLE REQUESTS.
2. YOU CAN REQUEST A RESTRICTION IN OUR USE OR DISCLOSURE OF YOUR HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS. ADDITIONALLY, YOU HAVE THE RIGHT TO REQUEST THAT WE RESTRICT OUR DISCLOSURE OF YOUR HEALTH INFORMATION TO ONLY CERTAIN INDIVIDUALS INVOLVED IN YOUR CARE OR THE PAYMENT OF YOUR CARE, SUCH AS FAMILY MEMBERS AND FRIENDS. WE ARE NOT REQUIRED TO AGREE TO YOUR REQUEST; HOWEVER, IF WE DO AGREE, WE ARE BOUND BY OUR AGREEMENT EXCEPT

WHEN OTHERWISE REQUIRED BY LAW, IN EMERGENCIES, OR WHEN THE INFORMATION IS NECESSARY TO TREAT YOU.

3. YOU HAVE THE RIGHT TO INSPECT AND OBTAIN A COPY OF THE HEALTH INFORMATION THAT MAY BE USED TO MAKE DECISIONS ABOUT YOU, INCLUDING PATIENT MEDICAL RECORDS AND BILLING RECORDS, BUT NOT INCLUDING PSYCHOTHERAPY NOTES. YOU MUST SUBMIT YOUR REQUEST IN WRITING TO:
   J. MICHAEL STOLLEY, D.C., STOLLEY WELLNESS CLINIC
   12122 SEMINOLE BLVD., LARGO, FLORIDA 33778
4. YOU MAY ASK US TO AMMEND YOUR HEALTH INFORMATION IF YOU BELIEVE IT IS INCORRECT OR INCOMPLETE, AND AS LONG AS THE INFORMATION IS KEPT BY OR FOR OUR PRACTICE. TO REQUEST AN AMENDMENT, YOUR REQUEST MUST BE MADE IN WRITING AND SUBMITTED TO:
   J. MICHAEL STOLLEY, D.C., STOLLEY WELLNESS CLINIC
   12122 SEMINOLE BLVD., LARGO, FLORIDA 33778
5. RIGHT TO A COPY OF THIS NOTICE. YOU ARE ENTITLED TO RECEIVE A COPY OF THIS NOTICE OF PRIVACY PRACTICES. YOU MAY ASK US TO GIVE YOU A COPY OF THIS NOTICE AT ANY TIME. TO OBTAIN A COPY OF THIS NOTICE, CONTACT:
   J. MICHAEL STOLLEY, D.C., STOLLEY WELLNESS CLINIC
   12122 SEMINOLE BLVD., LARGO, FLORIDA 33778
6. RIGHT TO FILE A COMPLAINT. IF YOU BELIEVE YOUR PRIVACY RIGHTS HAVE BEEN VIOLATED, YOU MAY FILE A COMPLAINT WITH OUR PRACTICE OR WITH THE SECRETARY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES. TO FILE A COMPLAINT WITH OUR PRACTICE, CONTACT:
   J. MICHAEL STOLLEY, D.C., STOLLEY WELLNESS CLINIC
   12122 SEMINOLE BLVD., LARGO, FLORIDA 33778

   ALL COMPLAINTS MUST BE SUBMITTED IN WRITING. YOU WILL NOT BE PENALIZED FOR FILING A COMPLAINT.
7. RIGHT TO PROVIDE AN AUTHORIZATION FOR OTHER USES AND DISCLOSURES. OUR PRACTICE WILL OBTAIN YOUR WRITTEN AUTHORIZATION FOR USES AND DISCLOSURES THAT ARE NOT IDENTIFIED BY THIS NOTICE OR PERMITTED BY APPLICABLE LAW.

IF YOU HAVE ANY QUESTIONS REGARDING THIS NOTICE OR OUR HEALTH INFORMATION PRIVACY POLICIES, PLEASE CONTACT

J. MICHAEL STOLLEY, D.C., STOLLEY WELLNESS CLINIC
12122 SEMINOLE BLVD., LARGO, FLORIDA 33778

I HEARBY ACKNOWLEDGE THAT I HAVE BEEN PRESENTED WITH A COPY OF FCFG'S NOTICE OF PRIVACY PRACTICE.

_____	_____	_____
PATIENT'S SIGNATURE	PATIENT'S PRINTED NAME	DATE

STOLLEY WELLNESS CLINIC

CASE HISTORY

NAME_____ DATE_____ CASE NUMBER_____

ADDRESS_____ CITY_____ STATE_____ ZIP_____

HOME PHONE_____ EMAIL ADDRESS_____

OCCUPATION_____ EMPLOYER_____ WK PHONE_____

CELL PHONE_____ MARITIAL: S M W D #CHILDREN_____

DATE OF BIRTH_____ SEX: M F AGE_____

SPOUSE'S NAME_____ SPOUSE'S OCCUPATION_____

SPOUSE'S EMPLOYER_____ SPOUSE'S WK PHONE_____

REFERRED BY_____

INSURANCE COMPANY_____

CURRENT COMPLAINTS:

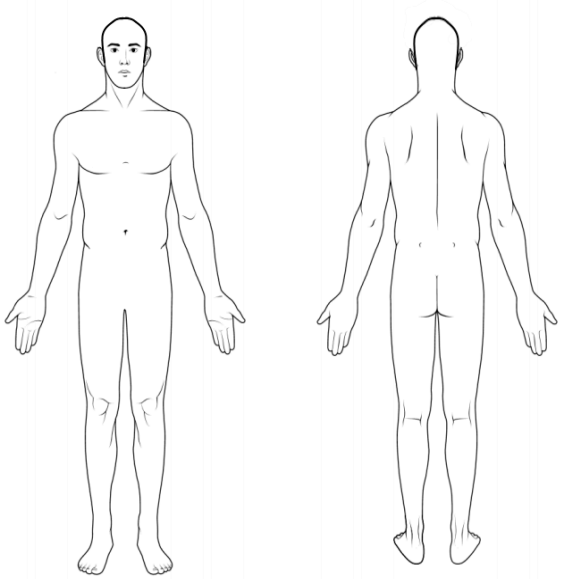
1. _____
2. _____
3. _____

CHIROPRACTIC HISTORY:

HAVE YOU EVER BEEN TO A CHIROPRACTER BEFORE: _____YES _____NO

IF YES, DOCTOR'S LAST NAME: _____

DATE OF LAST VISIT_____ REASON FOR CARE_____
DATE OF LAST X-RAY_____ HOW LONG WERE YOU UNDER CARE_____



HEALTH INFORMATION: PLEASE LIST SURGERIES, DISEASES, BROKEN BONES, AND AUTO ACCIDENTS:

_____

_____

_____

ON A SCALE OF ONE TO TEN, WITH TEN BEING THE MOST SEVERE I WOULD RATE MY PAIN AT:

1 2 3 4 5 6 7 8 9 10

NAME_____

HABITS

___SMOKING PACKS/DAY____

___DRINKING ALCHOHOL_____

___COFFE CUPS/DAY_____

EXERCISE

___NONE

___MODERATE

___DAILY TYPE_____

ARE YOU PRESENTLY TAKING ANY MEDICATIONS: YES NO

IF YES PLEASE LIST: _____

FAMILY HISTORY:	DIABETES	HEART	KIDNEY	CANCER	BACK
MOTHER	_____	_____	_____	_____	_____
FATHER	_____	_____	_____	_____	_____
BROTHER, #OF____	_____	_____	_____	_____	_____
SISTER, #OF____	_____	_____	_____	_____	_____

IF YOU HAVE HAD THE FOLLOWING, PLEASE CHECK:

	CONSTANTLY OR FREQUENTLY	OCCASIONALLY
HEADACHES	_____	_____
MIGRANES	_____	_____
NECK PAIN	_____	_____
SHOULDER PAIN	_____	_____
ARM/HAND PAIN	_____	_____
MID BACK PAIN	_____	_____
LOW BACK PAIN	_____	_____
HIP PAIN	_____	_____
LEG/FOOT PAIN	_____	_____
DISC PROBLEMS	_____	_____
JOINT PAIN	_____	_____
NUMBNESS	_____	_____
JOINT SWELLING	_____	_____
DIZZINESS	_____	_____
NAUSEA	_____	_____
WEAKNESS	_____	_____
FATIGUE	_____	_____
NERVOUSNESS	_____	_____
INSOMNIA	_____	_____
NOSE BLEEDS	_____	_____
RINGING IN EARS	_____	_____
EARACHES	_____	_____
HEARING LOSS	_____	_____
COUGH	_____	_____
CHEST PAINS	_____	_____
FEMALE PROBLEMS	_____	_____
ALLERGIES	_____	_____
DIGESTIVE PROBLEMS	_____	_____
URINARY PROBLEMS	_____	_____
FREQUENT COLDS	_____	_____