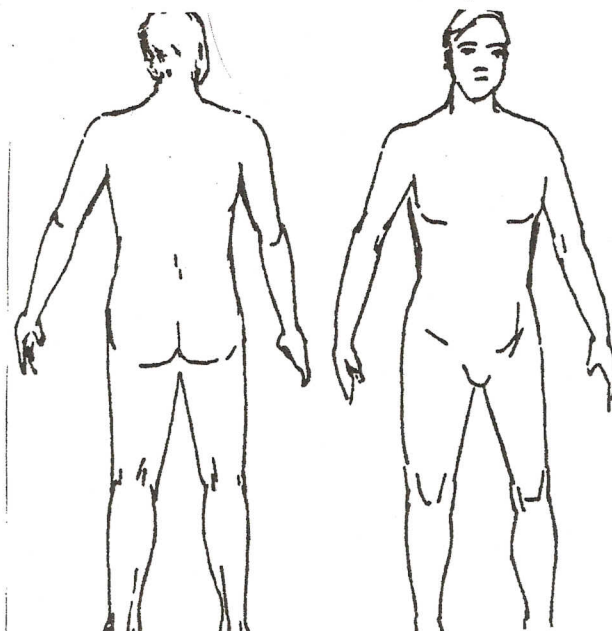


PAIN CHART

Please make an "x" where the pain is.



I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

Patient Signature _____

Date _____

Request For Payment of Benefits to Provider of Care

I hereby authorize the _____ Insurance Company/Insurance Administrator to pay by check, and for it to be mailed directly to: Dr. Andrew L. Kemp, D.C., the expense benefits allowable and otherwise payable to me under my current policy, as payment toward the total charges for professional services rendered. I have agreed to pay, in a current manner, any balance of said applicable charges. I agree that this office be given power of attorney to endorse/sign my name on my name on any and all drafts for payment of my bill.

Patient's Signature _____

To All Insurance Patients:

I understand and agree that health and accident insurance policies are an arrangement between and insurance carrier and myself. 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 remittances for the conveyance of credit to my account. **HOWEVER, I CLEARLY UNDERSTAND THAT ALL SERVICES RENDERED TO ME ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT.**

Patient's Signature: _____

X-Ray/Medical Records Release

I have requested the release of records of _____ which are part of the records at _____.

I hereby request and authorize you, your employees and agents to furnish to the person(s) listed below or anyone designated in writing by them, all copies of records and reports, including copies of x-rays and photostatic copies, abstracts or excerpts of all records and any other information they may request relating to any examination, treatment or opinion concerning any condition that I may have had in the past, now have, or may have in the future. Please forward this to:

Dr. Andrew L. Kemp, D.C.
1310 Seven Springs Blvd.
New Port Richey, FL 34655
Office: (727) 372-9500
Fax: (727) 372-1268

Patient Signature _____

Patient Pregnancy Disclaimer

At the present time:

- _____ I am sure that I am not pregnant.
- _____ It is possible that I could be pregnant.
- _____ I am pregnant.

Patient Signature _____ **Date** _____

Attorney Representation and Protection of Balance

I, the undersigned patient am directing by Attorney, _____, to pay any outstanding bills out of my settlement and, in effect, protecting any such balance. I hereby make and declare the instructions herein contained to be irrevocable. I fully understand that I am directly responsible for all medical bills and this agreement is made solely for the doctor's additional protection and consideration of his awaiting payment. I further understand that such payment is not contingent on any settlement, judgement or verdict by which I may eventually recover said fee. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment, but will require me to make payment on a current status.

Attorney Name: _____
Address: _____
Phone #: _____

Patient Signature _____

Consent For Treatment

I, the undersigned, hereby authorize Dr. Andrew L. Kemp, D.C., and whomever he may designate as his assistant to perform any examinations or diagnostic tests, including but not limited to radiographs, and to administer treatment as is necessary.

I, also, certify that no guarantee or assurance has been made to the results that may be obtained.

Patient's Signature _____

Consent For Treatment of a Minor

I hereby authorize Dr. Andrew L. Kemp, D.C., and whomever he may designate as his assistant, to perform diagnostic tests, including but not limited to radiographs, and to administer treatment as he deems necessary to my (indicate relationship of child) _____,
(child's name) _____.

Guardian's Signature _____

Authorization to Release Medical Information

I authorize the release of any medical information necessary to process my insurance claim(s) and also certify that all insurance information given to this clinic is correct and complete.

Patient Signature _____