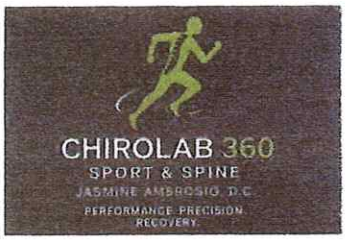


PATIENT INFORMATION & CONDITION FORM

Patient Name: _____ Today's Date: ___/___/___

Birth Date: ___/___/___ Age: ____ Gender: F M U Decline

Patient's E-mail address: _____

If you are under 18 years of age, who are your legal parents or guardian?

Father: _____ Date of Birth: ___/___/___ Phone: (____) _____

Mother: _____ Date of Birth: ___/___/___ Phone: (____) _____

Guardian: _____ Date of Birth: ___/___/___ Phone: (____) _____

Who do you normally live with? ☐ Mother and Father ☐ Father ☐ Mother ☐ Legal Guardian ☐ None of these

Marital Status: ☐ Married ☐ Separated ☐ Widowed ☐ Single How many children? _____

CURRENT ADDRESS

Street _____

City _____ State _____ Zip _____

Phone (____) _____

Your Occupation _____ Employer _____

Work Address _____ Work Phone (____) _____

Student at _____ ☐ FULL-TIME ☐ PART-TIME

Name of Spouse _____ Spouse's Date of Birth ___/___/___

Spouse's Occupation _____ Spouse's Employer _____

Spouse's Work Address _____ Work Phone (____) _____

Spouse is a student at _____ ☐ FULL-TIME ☐ PART-TIME

Who should we contact in the event of an emergency? _____

Relationship of emergency contact to patient: _____ Phone (____) _____

Address of contact person _____

How did you learn about us? _____

Is your condition or injury due to an accident or work-related cause? ☐ YES ☐ NO Date of accident: ___/___/___

Did the condition or injury result from *automobile* accident? ☐ YES ☐ NO Please check ALL that apply.

Did it result from a *work-related* accident or cause? ☐ YES ☐ NO (briefly describe): _____

_____

If the condition did not result from an automobile accident or relate to your work, where did the accident occur? _____

_____

Approximately, when did your injury or condition occur? ___/___/____

Describe your condition, symptoms, or the purpose of this appointment: _____

_____

Have you ever had the same or similar condition? ☐ YES ☐ NO If yes, when and describe: _____

_____

Please indicate any other healthcare providers who you've seen for this injury or condition, and when you last saw them.

Name: _____ Type of Practice: _____ Date of Last Visit: ___/___/____

Name: _____ Type of Practice: _____ Date of Last Visit: ___/___/____

Name: _____ Type of Practice: _____ Date of Last Visit: ___/___/____

Date of last physical examination? _____

What surgery have you had? _____ When? _____

Serious illnesses or conditions? _____ When? _____

Have you been treated for any health condition by a physician in the last year? ☐ YES ☐ NO

Describe: _____

What medications or drugs are you taking? _____

WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant? ☐ YES ☐ NO ☐ UNCERTAIN

Do you have health insurance? ☐ YES ☐ NO ☐ Not Sure Company: _____

Full Name of Policy Holder: _____ Policy Holder's Date of Birth ___/___/____

Health insurance Id: _____ Group number: _____ Does the policy holder have the insurance through his/her employer? ☐ YES ☐ NO If yes, who is the employer? _____

Attorney name: _____ Contact info: _____

****

I understand and agree that health and accident insurance policies are an arrangement between my insurance company and myself -- not between my insurance company and this office. I agree to pay my estimated patient responsibility and further understand that the estimated responsibility is neither a guarantee of payment by my insurance company, nor necessarily an accurate reflection of my actual responsibility as determined by my insurance company upon processing of my claims. In the event that my insurance company does not pay on my charges at the estimated rate or within a reasonable period of time, upon request of this office I will immediately pay the balance owing on my account unless otherwise agreed to in writing. I understand that an interest charge may appear on all accounts over 90 days. I further understand and agree, that if this office must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse this office for all costs of such collection efforts, including, but not limited to, all court costs and attorney fees.

I authorize this office to release any medical information relating to my treatment to any insurance companies which may be responsible for paying benefits to me, and to any attorney s who may be representing me due to my condition, and to complete any usual and customary reports and forms at no charge to assist in collecting from my insurance companies, attorneys, or other payers.
I have read, understood, and agree to the foregoing. The information which I have provided is true and complete to the best of my knowledge.

Patient's Signature: _____ Date: ___/___/____

Patient Name:_____ Date:_____

Chiropractic Intake Form

Chief Complaint:

What brings you to the office today? _____

When did it begin? _____

Does it interfere with: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation ☐ Other _____

Please explain: _____

How are your symptoms changing? ☐ Getting Better ☐ Not Changing ☐ Getting Worse

Are you currently or have you previously been treated for this problem? ☐ Y ☐ N

By whom: _____

Type of Treatment: _____

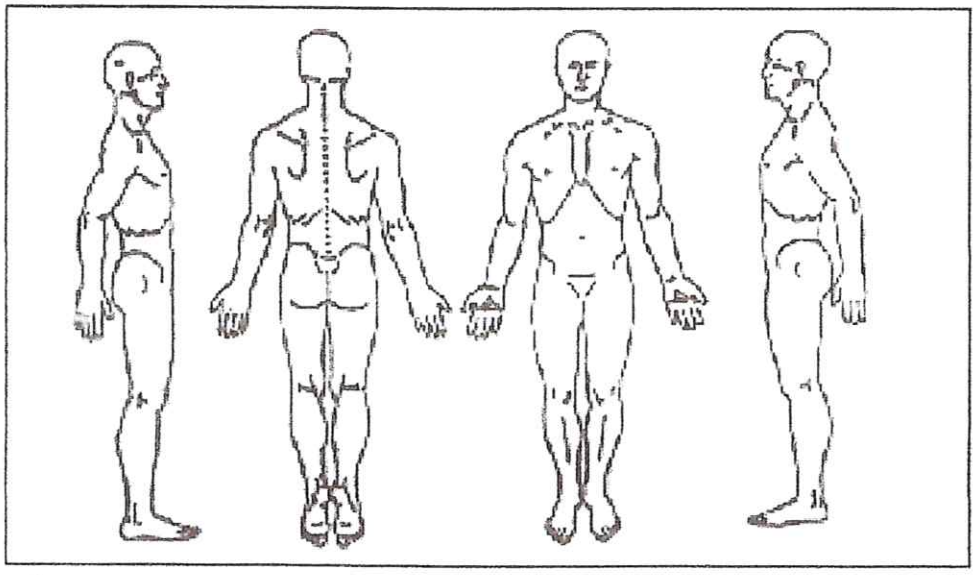
Is your condition due to an accident? ☐ Yes ☐ No Date of Accident: _____

Type of Accident: ☐ Auto ☐ Work ☐ Home ☐ Other _____

To who have you reported your accident?

☐ Auto Insurance ☐ Employer ☐ Workers Comp. ☐ Other _____

Attorney Name (if applicable): _____



Please draw location and type of pain on body outline.

Ache ^^^^^ ^^^	Burning ====== ====
Numbness oooooo oooo	Pins and Needles ....
Stabbing ////// ////	Other xxxxxx xxx

0 No Pain — 10 Worst Possible Pain

Please indicate level of pain on line with a mark

How often do you experience your symptoms?

☐ Constantly (76-100%) ☐ Frequently (51-75%) ☐ Occasionally (26-50%) ☐ Intermittently (0-25%)

Have you had these symptoms in the past? ☐ Yes ☐ No

Have you had any testing for your condition?

☐ X-Rays ☐ MRI ☐ CT Scan ☐ Other _____

When were these tests performed? _____

Dr.'s Initials: _____

Patient Name:_____ Date:_____

Health History/Medical Conditions: Have you had any of the following

☐ Alcoholism	☐ Drug Dependence	☐ Hypertension	☐ Prostate Disease
☐ Anemia	☐ Emphysema	☐ High Cholesterol	☐ Prosthesis
☐ Anorexia/Bulimia	☐ Epilepsy	☐ Kidney Disease	☐ Psychiatric Illness
☐ Asthma	☐ Eye Condition	☐ Liver Disease	☐ Sinus Problems/Allergies
☐ Arthritis	☐ Excessive Thirst	☐ Lupus	☐ Scoliosis
☐ Back/Neck Condition	☐ Fibromyalgia	☐ Lyme Disease	☐ Skin Disorder
☐ Bladder/Bowel Change	☐ Fractures	☐ Miscarriage	☐ Stroke
☐ Bleeding Disorder	☐ Frequent Urination	☐ Multiple Sclerosis	☐ Thyroid Problem
☐ Breast Lump	☐ Gall Bladder Disease	☐ Neurologic Condition	☐ Tuberculosis
☐ Cancer	☐ Gout	☐ Osteoporosis	☐ Ulcers
☐ Chemical Dependency	☐ Headaches	☐ Pacemaker	☐ Urinary Tract Infections
☐ Chicken Pox	☐ Heart Disease	☐ Parkinson's Disease	☐ Vascular Disease
☐ Depression/Anxiety	☐ Hepatitis	☐ Pinched Nerve	☐ Venereal Disease
☐ Diabetes	☐ Hernia	☐ Polio	☐ Weight gain/Loss
☐ Dizziness	☐ Herniated Disk	☐ Pregnancy	☐ Other_____

Surgical History

☐ Abdominal/Gastrointestinal	☐ Gynecological/Genitourinary	☐ Prostate
☐ Back Surgery	☐ Joint Procedure	☐ Skin Procedure
☐ Cardiovascular Procedure	☐ Neck Surgery	☐ Other _____

Please describe any hospitalizations or surgeries below (please include approximate date):

_____

_____

_____

Allergies:

☐ Environmental	☐ Food	☐ Seasonal
☐ Latex	☐ Medications	☐ Other _____

Please describe allergies below:

_____

_____

Social History

Personal Habits:

Have you ever smoked? ☐ Yes ☐ No For how long?

_____

☐ Tobacco	packs/day	_____
☐ Alcohol	drinks/wk	_____
☐ Coffee/tea/cola	cups/day	_____
☐ Recreational drugs	times/wk	_____

Stress level

☐ Mild ☐ Moderate ☐ Severe

Any dietary restrictions?
If yes, describe

_____

_____

Work Activity Level

☐ Sitting	% of time _____
☐ Standing	% of time _____
☐ Light Labor	% of time _____
☐ Heavy Labor	% of time _____

Exercise

Do you exercise regularly? ☐ Y ☐ N

If yes, describe routine and how often: _____

_____

_____

_____

_____

_____

In general how is your overall health right now? ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

Dr 's Initials:

Patient Name:_____ Date:_____

Family History

- ☐ Arthritis
- ☐ Heart Problems
- ☐ Thyroid
- ☐ Cancer
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Psychiatric
- ☐ Stroke
- ☐ Other _____

Please describe below

_____

_____

Medications & Supplements

Please list any medications and supplements you are currently taken or have used in the last 90 days.

Medications	Supplements

Occupation:

- ☐ Professional/Executive
- ☐ White Collar/Secretarial
- ☐ Laborer
- ☐ Tradesperson
- ☐ Homemaker
- ☐ Student
- ☐ Retired
- ☐ Other _____

- ☐ Full-Time
- ☐ Part-Time
- ☐ Self-Employed
- ☐ Unemployed
- ☐ Off Work
- ☐ Other _____

Please describe daily work activities:

_____

_____

_____

Is there anything else the doctor should know about your current condition or your health history that has not already been covered?

_____

_____

_____

_____

_____

_____

Dr.'s Initials: JD

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOU YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

NOTICE OF PRIVACY AND INFORMATION PRACTICES

This Notice of Privacy Practices is provided to you by _____ (hereinafter "we" or "company") as a requirement of the Health Insurance Portability and Accountability Act (HIPAA). It describes how we may use or disclose your protected health information, with whom that information may be shared, and the safeguard we have in place to protect it. This notice also describes your rights to access and amend your protected health information. You have the right to approve or refuse the release of specific information outside of our system except when the release is required or authorized by law or regulation.

Acknowledgement of Receipt of this Notice. You will be asked to provide a signed acknowledgement of receipt of this Notice. Our intent is to make you aware of the possible uses and disclosures of your protected health information and your privacy rights. The delivery of your health care services will in no way be conditioned upon your signed acknowledgement. If you decline to provide a signed acknowledgement, we will continue to provide your treatment, and will use and disclose your protected health information for treatment, payment, and health care operations when necessary.

Our Duties to You Regarding Your Protected Health Information (PHI). PHI is individually identifiable health information. This information includes demographics, for example, age, address, e-mail address, and relates to your past, present, or future physical or mental health or condition and related health care services. We are required by law to do the following:

1. Make sure that your PHI is kept private;
2. Give you this notice of our legal duties and privacy practices related to the use and disclosure of your PHI;
3. Follow the terms of this notice currently in effect; and
4. Communicate any changes in the notice to you.

Company reserves the right to change the terms of its notice and to make new notice provisions effective for all protected health information that it maintains. Company will provide each patient with a copy of any revisions of its Notice of Information Practice at the time of their next visit, or at their last known address if there is a need to use or disclose any protected health information of the patient. Copies may also be obtained at any time at our offices.

Permitted Uses: Treatment, Payment and Healthcare Operations. We may use and disclose protected health information for treatment, payment and healthcare operations. Treatment examples include, but are not limited to requested preschool, life insurance or sports physicals; referral to nursing homes, foster care homes, or home health agencies; or referrals to other providers for treatment. Payment examples include, but are not limited to completing a claim form to obtain payment from an insurer or activities that we might undertake to determine eligibility or coverage for benefits. Healthcare operations include, but are not limited to, investigations, implementing compliance programs, oversight or staff performance reviews, and internal quality control assurance including auditing of records.

Other Permitted Uses. Company is permitted or required to use or disclose protected health information without the individual's written authorization in certain circumstances. These include the following:

1. Required Uses and Disclosures. By law, we must disclose your health information to you unless it has been determined by a competent medical authority that it would be harmful to you. We must also disclose health information to the Secretary of the Department of Health and Human Services for investigations or determinations of our compliance with laws on the protection of your health information. We may use or disclose your PHI if a law or regulation requires the use or disclosure.

2. Business Associates. We will share your PHI with third party "business associates" who perform various activities for us. Examples are billing services or transcription services. The business associates will be required to sign a Business Associate Agreement and they will be required to protect your health information.

3. Contacting You. We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment. We may call you by name in the waiting room when your health care provider is ready to see you.

4. Treatment Alternatives. We may use or disclose your PHI to provide you with information about treatment alternatives or other health-related benefits and services that might interest you. For example, your name and address may be used to send you a newsletter about services we offer. We may also send you information about products or services that might benefit you.

5. Public Health. We may disclose your PHI to a public health authority who is permitted by law to collect or receive the information. The disclosure may be necessary to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition. We may notify the appropriate government authority if we believe a patient has been a victim of abuse, neglect, or domestic violence.

6. Communicable Diseases. We may disclose your PHI, if authorized by law, to a person who might have been exposed to a communicable disease or might otherwise be at risk of contracting or spreading the disease or condition.

7. Health Oversight. We may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations and inspections. These health oversight agencies might include government agencies that oversee the health care system, government benefits programs, other government regulatory programs, and civil rights laws.

8. Food and Drug Administration. We may disclose your protected health information to a person or company required by the FDA to do the following: report adverse events, product defects, or problems and biologic product deviations; tract products; enable product recalls; make repairs or replacements; or conduct post-marketing surveillance as required.

9. Legal Proceedings. We may disclose PHI during any judicial or administrative proceeding, in response to a court order or administrative tribunal (if such a disclosure is expressly authorized), and in certain conditions in response to a subpoena, discovery request, or other lawful process.

10. Law Enforcement. We may disclose PHI for law enforcement purposes, including responses to legal proceedings, information requests for identification and location, circumstances pertaining to

victims of a crime, deaths suspected from criminal conduct, crimes occurring at our office site, and medical emergencies believed to result from criminal conduct.

11. Coroners, Funeral Directors and Organ Donations. We may disclose PHI to coroners or medical examiners for identification to determine the cause of death or for the performance of other duties authorized by law. We may also disclose PHI to funeral directors if authorized by law. PHI may be used and disclosed for cadaveric organ, eye, or tissue donations.

12. Research. We may disclose your PHI to researchers when authorized by law, for example, if their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your PHI.

13. Criminal Activity. Under applicable federal and state laws, we may disclose your PHI if we believe that its use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose PHI if it is necessary for law enforcement authorities to identify or apprehend an individual.

14. Military Activity and National Security. When the appropriate conditions apply, we may use or disclose PHI of individuals who are Armed Forces personnel (1) for activities believed necessary or appropriate military command authorities to ensure the proper execution of the military mission including determination of fitness for duty; (2) for determination by the Department of Veterans Affairs of your eligibility for benefits; or (3) to a foreign military authority if you are a member of that foreign military service. We may also disclose your PHI to authorized federal officials for conducting national security and intelligence activities including protective services to the President or others.

15. Workers' Compensation. We may disclose your PHI to comply with workers' compensation laws and other similar legally established programs. We will act consistently with the law of the Commonwealth of Pennsylvania and will make disclosures following such laws.

16. Inmates. We may use or disclose your PHI if you are an inmate of a correctional facility, and we created or received your PHI information while providing care to you. This disclosure would be necessary (1) for the institution to provide you with care, (2) for your health and safety or that of others, or (3) for the safety and security of the correctional institution.

17. Parental Access. We may use or disclose PHI to parents, guardians and persons acting in a similar legal status. We will act consistently with the law of the Commonwealth of Pennsylvania and will make disclosures following such laws.

18. Family Members. Unless you object, we may release protected health information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. We may also tell your family or friends the condition that you are in. You will be provided a form to list specific people who we may speak to regarding your medical care. In addition, we may disclose protected health information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

19. Fundraising. Company may use protected health information about you to contact you in an effort to raise money for our practice and its operations. We may disclose protected health information to a related foundation so that the foundation may contact you in raising money. We only would release contact information, such as your name, address and phone number and the dates you

received treatment or services. If you do not want us to contact you for fundraising efforts, you must notify our practice in writing.

Authorization Required. Company will not make any other use or disclosure of your protected health information without your written and valid authorization. Such use or disclosure must be consistent with such authorization. Authorization is specifically required for the following:

1. Psychotherapy Notes. We must obtain an authorization for any use or disclosure of psychotherapy notes, except: to carry out the following treatment, payment, or health care operations: (A) use by the originator of the psychotherapy notes for treatment; (B) use or disclosure by the covered entity for its own training programs in which students, trainees, or practitioners in mental health learn under supervision to practice or improve their skills in group, joint, family, or individual counseling; or (C) use or disclosure by the covered entity to defend itself in a legal action or other proceeding brought by the individual.
2. Marketing. We must obtain an authorization for any use or disclosure of protected health information for marketing, except if the communication is in the form of: (A) A face-to-face communication made by a covered entity to an individual; or (B) A promotional gift of nominal value provided by the covered entity. If the marketing involves financial remuneration to us from a third party, the authorization must state that such remuneration is involved.
3. Sale of protected health information. We must obtain an authorization for any disclosure of protected health information which is a sale of protected health information. The authorization must state that the disclosure will result in remuneration to the covered entity.

Revoking Authorization. You may revoke the authorization at any time provided that the revocation is in writing, except to the extent that: (A) we have not taken action in reliance thereon or (B) if the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

Patient Rights. Patients have been granted individual rights under the HIPAA Legislation. These include the following:

1. Inspect and copy. You have the right to inspect and copy protected health information that may be used to make decisions about your care. You have the right to a paper copy. Usually, this includes medical and billing records, but does not include psychotherapy notes, information complied in reasonable anticipation of or use in a civil, criminal or administrative action or proceeding, or Protected Health Information that is subject to or exempt from the Clinical Laboratories Act of 1988. To inspect and copy protected health information that may be used to make decisions about you, you must submit your request in writing us. If you request a copy of the information, we may charge a fee for the costs of copying (including labor), mailing or other supplies associated with your request.

2. Amend. If you feel that protected health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is maintained in the designated record set. To request an amendment, your request must be made in writing and submitted to us. You must provide a reason that supports your request and we may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that was not created by us, unless the person or entity that created the information is no longer available to make the amendment, is not part of the protected health information kept by or for our practice; is not part of the information which you would be permitted to inspect and copy; or is accurate and complete. We may deny your request to inspect and copy in certain very limited

circumstances. If you are denied access to protected health information, you may request that the denial be reviewed. Another licensed health care professional chosen by our organization will review your request and the denial. The person conducting the review will not be the person who denied your request and we will comply with the outcome of the review.

3. Accounting of disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of protected health information about you that was not made for treatment, payment and health care operations and there are certain exceptions to this right. To request this list or accounting of disclosures, you must submit your request in writing to us. Your request must state a time period, which may not be longer than six years prior to the date you request the accounting. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred. The accounting must be provided to you no later than 60 days after the receipt of your request, unless we utilize the 30-day extension period.

4. Restrictions on uses or disclosures. You have the right to request a restriction or limitation on the protected health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the protected health information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to us. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse. Either you or we may terminate the restriction upon notification of the other.

5. Confidential communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to us. We will ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

6. Complaints. You may complain to us and to the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated. It is Company's policy that no retaliatory action will be made against any individual who submits or conveys a complaint of suspected or actual non-compliance of the privacy standards. You may file a Complaint with us by sending a written complaint to us.

You will be asked to outline or define specific instances or information that you would like kept completely confidential (between you and us). If you have any questions regarding this Notice of Privacy Practices, please do not hesitate to contact us for more information or clarification. You may contact the following:

NAME: _____

PHONE: _____

The effective date of this agreement is this _____ day of _____, 20____

PATIENT CONSENT FORM

Regarding the Use & Disclosure of Protected Health Information

("Consent Form")

For the purposes of this Consent Form, "Office" shall refer to: **Chirolab360 Sport & Spine**

I understand that some of my health information may be used and/or disclosed by the Office to carry out treatment, payment, or health care operations, and that for a more complete description of such uses and disclosures I should refer to the Office's privacy notice entitled, "Our Privacy Practices." I understand that I may review this privacy notice at any time prior signing this form.

I understand that over time the Office's privacy practices may need to change in accordance with law and that if I wish to obtain a copy of the notice as revised, I can call the Office to request such copy.

I understand that I may request restrictions on how my information is used or disclosed to carry out treatment, payment, or health care operations, and that I can also revoke this Consent in, but only to the extent that the Office has not taken action in reliance thereon and also provided that I do so in writing.

I understand that for my protection, any requests to amend my health information or to access my medical records must be made in writing.

Patient Name (please print): _____

Signature: _____ Date: ___/___/___

ChiroLab 360: Sport & Spine

Jasmine Ambrosio, DC
3800 Lake Center Drive, Suite B4 • Mount Dora, FL 32757
Phone: 352-663-8857 • Fax: 352-672-9611

ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

Patient Name: _____ Medicare ID #: _____

Date: _____

Medicare may not pay for the services listed below. If Medicare does not pay, you may be responsible for payment.

Services Medicare May Not Pay For (check all that apply)

☐ Shockwave Therapy (Extracorporeal Shockwave Therapy)

☐ Manual Therapy

☐ Heat Therapy / Thermal Modalities

Reason Medicare May Not Pay

Medicare may not pay for the services listed above because they may be considered not medically necessary or not covered under Medicare guidelines for your condition.

Estimated Cost (per service)

Shockwave Therapy (Individual Session): $150
Manual Therapy: $45
Heat Therapy / Thermal Modalities: $4
Estimated Total Cost: $_____

Patient Options (select ONE)

☐ OPTION 1 – Bill Medicare (you agree to pay if Medicare denies)

☐ OPTION 2 – Decline the services listed above

☐ OPTION 3 – Pay Cash (services will not be billed to Medicare)

I understand that Medicare may not cover the services listed above. I have had the opportunity to ask questions and understand my financial responsibility and payment options.

Patient Signature: _____ Date: _____

Printed Name: _____