



North Orlando Spine Center, LLC

Team-Based Chiropractic & Rehabilitation Solutions

Dr. Nicole Ingrando
Dr. Amanda Connelly
Dr. Aaron Proctor
Dr. Adam Sproat
Dr. Melanie Milner

Cancellation & No Show Policy

Cancellation Policy

At North Orlando Spine Center, we understand that unanticipated events happen occasionally in everyone’s life. In our desire to be effective and fair to all clients, the following policies are honored:

- **24 hour advance notice is required** when cancelling an appointment. This allows the opportunity for someone else to schedule an appointment. If you are unable to give us 24 hours advance notice you will be charged a cancellation fee for your appointment. This amount must be paid prior to your next scheduled appointment.
- **No-shows**
Anyone who either forgets or consciously chooses to forgo their appointment for whatever reason will be considered a “no-show.” They will be charged a cancellation for their “missed” appointment.
- **Late Arrivals**
If you arrive late, your session may be shortened in order to accommodate others whose appointments follow yours. Depending upon how late you arrive, your therapist will then determine if there is enough time remaining to start a treatment. Regardless of the length of the treatment actually given, you will be responsible for the “full” session. Out of respect and consideration to your therapist and other patients, please plan accordingly and be on time.
- **Arrival at the Office**

Please arrive for your appointment 10 minutes prior to the scheduled start time in order to ensure a complete session. This allows you the time to fill out any appropriate forms, change clothing if necessary, and prepare for your treatment. It will also help you slow down and catch your breath from your busy day!

The cancellation policy gives us time to inform our standby guests of any availability, as well as keeping North Orlando Spine Center’s schedule full, thus better serving everyone. Thank you for being understanding and supporting our policy. We look forward to serving you!

Patient Signature

Date

Patient Name (Please Print)

North Orlando Spine Center, LLC
2160 West SR 434, Suite 108, Longwood, FL 32779
Phone: 407-331-9913 Fax: 407-331-9918



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Patient Name: _____ Gender: **M** **F**

How would you like us to refer to you? _____

Home Phone _____ Cell _____ Work _____

Address _____ City _____ State (abr.) _____ Zip _____

Date of Birth: ____/____/____ Age: _____ Email: _____

Social Security # _____ - _____ - _____ Marital Status: **Single** **Married** **Other**

Employment Status: Employed/ Full-Time Student/ Part- Time Student/ Retired / Other

Occupation: _____ Employer Name: _____

Employer Address: _____ City _____ State (Abr.) _____ Zip _____

Who is your Medical Doctor? _____ Dentist _____

OB/GYN _____

Is your condition related to an auto accident? **YES / NO** Date of Accident: ____/____/____

Do you have an attorney? **YES / NO** If so what is your attorney's name? _____

Patient Signature _____ **Date** ____/____/____

Spouse or Guardian Signature _____ **Date** ____/____/____

By signing above, I (we) agree to pay for services rendered to the above mentioned patient as the charge is incurred. I (we) understand that health and accident insurance policies are arrangements between an insurance carrier and myself and that I am personally responsible for payment of any and all services, covered or non-covered. If the doctor is a contracted provider for my managed care plan, I understand that I am responsible for all co-payments and non-covered services. I also understand and agree to pay all co-pays and fees for non-covered services prior to seeing a doctor. I (we) authorize the doctor and his staff to release any information deemed appropriate concerning my physical condition to any insurance company, claims adjuster, case nurse, claims reviewer, employer, healthcare provider or attorney in order to process any claim for reimbursement or charges incurred by me as a result of professional services rendered and hereby release him/her of any consequences thereof. I agree that a photo static copy of this arrangement shall serve as the original. I (we) hereby authorize and direct payment of any medical/Chiropractic expense benefits allowable to the doctor as payment toward the total charges for professional services rendered.

Records Reviewed on _____

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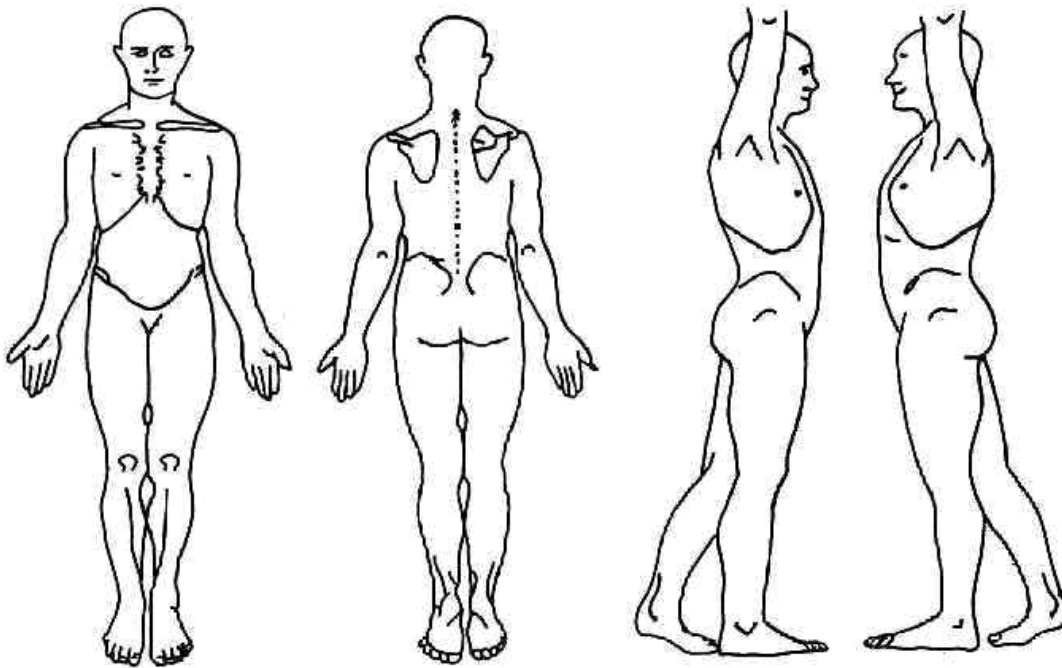
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Patient Name: _____

Date: ____/____/____

By using the key below, indicate on the body diagram where you are experiencing the following symptoms:

= Numbness X = Burning / = Stabbing O = Pins and Needles * = Dull Ache



Please describe your symptoms below:

How did your symptoms begin? (Home, gym, work, etc.) _____

When did your symptoms start? Month _____ Day _____ Year _____

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Patient Name: _____

Surgeries:

- Cardiovascular procedure
- Lumbar disc procedure
- cervical disc procedure
- Hysterectomy
- Pacemaker
- Joint replacement
- Laminectomies

Surgery :	Year:

Social History:

- Caffeine used occasionally
- Caffeine used often
- Chew tobacco occasionally
- Chew tobacco often
- Drink alcohol occasionally
- Drink alcohol often
- Exercise not at all
- Exercise occasionally
- Exercise often
- Experience occasional stress
- Experience stress often
- Smoke more than 1 pk per day
- Smoke 1 pk or less per day
- Former smoker
- Non smoker
- never wears seat belts
- Wears seat belts usually
- Wears seat belts always

Family History: (Check all that apply)

- Arthritis
- mother
- father
- brother
- sister
- grandmother
- grandfather
- Cancer
- mother
- father
- brother
- sister
- grandmother
- grandfather
- Cholesterol
- mother
- father
- brother
- sister
- grandmother
- grandfather
- Diabetes
- mother
- father
- brother
- sister
- grandmother
- grandfather
- Heart problems
- mother
- father
- brother
- sister
- grandmother
- grandfather
- High Blood Pressure
- mother
- father
- brother
- sister
- grandmother
- grandfather
- Psychiatric
- mother
- father
- brother
- sister
- grandmother
- grandfather
- Stroke
- mother
- father
- brother
- sister
- grandmother
- grandfather
- Thyroid
- mother
- father
- brother
- sister
- grandmother
- grandfather

Is your mother still living? Yes or No if no, what was her cause of death? _____

Is your father still living? Yes or No if no, what was his cause of death? _____

Are your siblings still living? Yes or No if no please indicate which sibling and cause of death _____

Are your grandparents still living? Yes or No

Substance Use:

- Alcohol (past)
- Alcohol (present)
- Amphetamines (past)
- Amphetamines (Present)
- Barbiturates (past)
- Barbiturates (present)
- Cocaine (past)
- Cocaine (present)
- Crystal Meth (past)
- Crystal Meth (present)
- Heroin (past)

Male Children: Under 6 years under 10 years Under 19 years

Female Children: Under 6 years under 10 years Under 19 years

- Occupational Activities: Administration Clerical/Secretarial Computer User Construction Daycare/Childcare
- Food Service Industry Healthcare Heavy Equipment Oper. Heavy Manual Labor Household Light Manual Labor
- Manufacturing Medium Manual Labor

Are you right or left handed? _____

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Patient Name: _____

Allergies:

Please list any allergies to food, medication and other factors:

Current Medications:

Dosage:

Current Medications:	Dosage:

ADDITIONAL QUESTIONS

- | | |
|--|-----|
| Do you have problems with recurring headaches? | Y N |
| Have you lost weight without trying? | Y N |
| Does your pain wake you at night? | Y N |
| Have you had a change in bowel or bladder habits? | Y N |
| Have you had a sore that doesn't heal? | Y N |
| Have you recently had any unusual bleeding or discharge? | Y N |
| Do you have thickening/lump in the breast or anywhere? | Y N |
| Do you have indigestion or difficulty swallowing? | Y N |
| Have you had an obvious change in a wart or mole? | Y N |
| Do you have a nagging cough or hoarseness? | Y N |

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Patient Name:

Review of Systems	Present	Past	N/A	Present	Past	N/A	Present	Past	N/A
Cardiovascular				Integumentary			Eyes		
Poor Circulation				Skin Lesions			Glaucoma		
High Blood Pressure				Skin Ulcers			Double Vision		
Aortic Aneurism				Skin Disease			Blurred Vision		
Heart Disease				Eczema			Neurological		
Vascular Disease				Psoriasis			Stroke		
Heart Attack				Rashes			Seizures		
Chest Pain				Allergic/Immune			Head Injury		
High Cholesterol				Hives			Brain Aneurysm		
Pace Maker				Immune Disorder			Numbness		
Jaw Pain				HIV/AIDS			Severe Headaches		
Irregular Heartbeat				Allergy Shots			Pinched Nerves		
Swelling of Legs				Cortisone Use			Parkinson's		
Genitourinary				Gastrointestinal			Carpal Tunnel		
Kidney Disease				Gallbladder Problems			Comments:		
Lower Side Pain				Bowel Problems					
Burning Urination				Constipation					
Blood in Urine				Liver Problems					
Kidney Stone				Ulcers					
Hematological/Lymph				Diarrhea					
Hepatitis				Nausea/Vomiting					
Blood Clots				Bloody Stools					
Cancer				Poor Appetite					
Easy Bruising				Musculoskeletal					
Easy Bleeding				Gout					
Ever/Sweats/Chills				Arthritis					
Respiratory				Joint Stiffness					
Asthma				Muscle Weakness					
Tuberculosis				Osteoporosis					
Shortness of Breath				Broken Bones					
Emphysema				Joints Replaced					
Cold/Flu				Endocrine					
Coughing/Wheezing				Thyroid Disease					
Ear/Nose/Throat				Diabetes					
Dizziness				Hair Loss					
Hearing Loss				Menopause					
Sinus Infection				Menstrual Problems					
Nose Bleed				Psychiatric					
Sore Throat				Depression					
Difficulty Swallowing				Anxiety Disorder					
Bleeding Gums				Unusual Stress					
				Weight Loss/Gain					

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AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

This authorization may be used to permit a covered entity to use or disclose an individual's protected health information. Individuals completing this form should read the form in its entirety before signing and complete all the sections that apply to their decisions relating to the use or disclosure of their protected health information.

Information regarding patient for whom authorization is made:

Full Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: (____) _____ Email (Optional): _____

Information regarding health care provider or health care entity authorized to disclose this information:

Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: (____) _____ Fax: (____) _____

Information regarding person or entity who can receive and use this information:

Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: (____) _____ Fax: (____) _____

Documents Requested:

- Imaging Reports
- Clinical Notes
- Lab Reports
- Other: _____

_____ I wish to revoke this authorization

Patient/Legal Guardian Signature _____ Date: _____

Assignment of Benefits

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I, the undersigned patient insured, knowingly, voluntarily and intentionally assign and transfer any and all rights and benefits of my automobile insurance policy (i.e. Personal Injury Protection ("PIP"), Uninsured Motorist and Medical Payments benefits) to the above-stated Health Care Provider. I understand it is the intention of the Health Care Provider to accept this Assignment of Benefits in lieu of demanding payment at the time services are rendered. I understand that this document will allow the Health Care Provider to file suit against the insurer either in my name or the provider's name for payment of the insurance benefits, to obtain an explanation of benefits and to seek attorneys fees and costs under Fla. Stat. §§627.736(S), 627.428 and 57.041 from the insurer. This Assignment of Benefits includes, but is not limited to, the cost of medical care, transportation, medication, 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 Health Care Provider in writing within five (5) days of receipt of this document advising of its basis for such dispute. Failure to inform the Health Care Provider shall result in a waiver by the insurer to contest the validity of this Assignment of Benefits. The undersigned patient insured directs the insurer to pay the Health Care Provider the maximum amount of the policy benefits directly to the Health Care Provider without any reductions and without including the undersigned patient's insured's name on the check. It is this Health Care Provider's contention that its charges are reasonable.

This Assignment of Benefits applies to past, present and future medical expenses and is valid even if not dated. A photocopy of this Assignment of Benefits is to be considered as valid as the original. I, the undersigned patient/insured, agree to pay any applicable deductible or co-payments for services rendered, including payment for services after the policy of insurance exhausts and for any other services unrelated to the date of injury. The above-stated Health Care Provider is given Power of Attorney to: (1) endorse my, the undersigned patient's /insured's, name on any check for services rendered by the above-stated Health Care Provider, (2) to request and obtain copies of any recorded statements or Examinations Under Oath given by me, the undersigned patient /insured, and (3) to request and obtain copies of any Independent Medical Examination report and/or peer review report pertaining to me, the undersigned patient insured.

Disputes

The insurer is directed by the Health Care Provider and the undersigned patient/insured not to issue any checks or drafts in partial settlement of a claim that contain or are accompanied by language releasing the insurer or its insured patient from liability unless there is a written settlement agreement between the Health Care Provider, specifically the Office Manager, and the insurer as to the amount to be paid by the insurer for the services rendered only to the undersigned patient, insured. The undersigned patient insured and the Health Care Provider hereby contest and object to any reductions or partial payments made by the insurer. Any partial or reduced payment, regardless of the accompanying language, issued by the insurer and deposited by the Health Care 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 Health Care Provider to accept a reduced amount as payment in full. The insurer is hereby placed on notice that this Health Care Provider reserves the right to seek payment in full for the bills submitted. If the insurer asserts that it can pay claims at 200% of the Medicare Fee Schedule, then the insurer is instructed and directed to provide this Health Care Provider with a copy of the policy of insurance within ten (10) days. Should the insurer and Office Manager of the above-stated Health Care Provider reach an agreement to settle any of the bills submitted at a reduced amount, this agreement shall be reduced to writing and submitted to the attention of the Office Manager for written approval. See Fla. Stat. §673.3111.

Release of Information

I, the undersigned patient/ insured, hereby authorize this Health Care Provider to: furnish an insurer, an insurer's intermediary, my other medical providers and my attorney(s) via mail, facsimile or e-mail, with any and all information that may be contained within my medical records to: obtain insurance coverage information (i.e. declarations page and policy of insurance) in writing and telephonically from the insurer, request from any insurer all Explanation of Benefits/Review forms (EOBs) for all of my medical providers, obtain a non-redacted PIP payout sheet, obtain written and verbal statements that I 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, peer reviews and MRIs from any of my medical providers or any insurer. The Health Care Provider is permitted to produce my medical records to its attorney in connection with pursuing a legal action. The insurer is directed to keep my, the undersigned patient's/insured's medical records confidential. The insurer is not authorized to provide my, the undersigned patient's/ insured's, medical records to anyone without my, the undersigned patient's/insured's and the Health Care Provider's express written permission.

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MEDICARE PATIENT CERTIFICATION — PATIENTS CERTIFICATION AUTHORIZATION TO RELEASE

INFORMATION AND PAYMENT REQUEST: I certify that the information given by me in applying for payment under Title XVIII and or Title XI of the Social Security Act is correct. I authorize any holder of medical or other information about me, to release to the Social Security Administration or its Intermediary carriers, any information needed for this or related Medicare claims. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable to North Orlando Spine Center, LLC, for physician(s) services. I understand that I am responsible for my health insurance deductibles and coinsurance.

Missed Appointment Policy: In an effort to accommodate other patients seeking an appointment, we ask that you notify us within 24 hours if you need to change or cancel your appointment. **North Orlando Spine Center, LLC reserves the right to charge up to a \$100 fee for missed appointments without proper notification.**

WOMEN: Verification of Pregnancy: By my signature, I do hereby state that, to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this particular time. If I am pregnant, by my signature, I confirm that I have made the physician(s) aware of my pregnancy.

Acknowledgment of receipt of Privacy Practices: By my signature, I have received and understand the Notice of Privacy Practices of North Orlando Spine Center, LLC, which describes the practice's policies and procedures regarding the use and disclosure of any of my protected health information created, received or maintained by the practice.

Certification

I, the undersigned patient/ insured, certify that: I have read and agree to the above; I have not been solicited or promised anything in exchange for receiving health care from the above-stated Health Care Provider; I have not received any promises or guarantees from anyone as to the results that may be obtained by any treatment or service provided; and I agree that the Health Care Provider's prices for the medical services, treatment and supplies provided are reasonable, usual and customary.

Caution: Please read this document carefully before signing. Please ask to review a copy of the above-stated Health Care Provider's charges. If you do not completely understand this document, please ask the front desk personnel or the medical provider to explain it to you. If you sign below it will be understood that you understand and agree with the contents of this Assignment of Insurance Benefits.

Patient Insured Name: _____

(Please Print)

Patient /Insured Signature: _____ **Date:** _____

(If patient/insured is a minor, signature of parent/guardian)

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North Orlando Spine Center Chiropractic and Rehabilitation Services Informed Consent Document

To the Patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if anything is unclear.

The nature of frequent conservative care at our office.

Manual therapy - One of the treatment options used by our Doctors and assistants. We may use our hands or be assisted by a handheld tool to break up or loosen myofascial adhesions and musculoskeletal tightness.

Therapeutic exercise - One of the treatment options used by our Doctors and assistants. We may provide passive stretching to loosen a tight muscle/joint done with our hands or assisted with a handheld tool. We may prescribe active care to be done in the office or at home to loosen a tight muscle/joint or to stabilize a weakened area.

Neuromuscular re-education/Therapeutic procedures - One of the treatment options used by our Doctors and assistants. We may provide treatment of a joint or body region done with movement and stimulation to the mechanoreceptors in efforts to improve the stability or the region, improve the postural neutral position, alter the muscle memory, and/or decrease tightness and pain.

Chiropractic adjustment - One of the treatments used by the Doctors is manipulative therapy. The Doctors may use this procedure on you with their hands or a mechanical instrument to provide a force into a restricted joint.

Analysis/Examination/Treatment

As part of the analysis, examination, and treatment, you are consenting to the following procedures:

palpation, vital signs, neurological examination, range of motion testing, orthopedic/physical testing, postural analysis, ultrasound, hot/cold therapy, EMS, manual therapy, therapeutic exercise, neuromuscular re-education/therapeutic procedures, chiropractic adjustment

other:

exclusions:

The material risks inherent in treatment.

As with any healthcare procedure, there are certain complications which may arise during treatment. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains or separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. The Doctor will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to the Doctor's attention it is your responsibility to inform the Doctor.

The probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history, examination, and any imaging reviewed or ordered. Stroke and/or arterial dissection is a subject of much medical research. Currently, the found causal relations if at all is extremely rare and remote. Unfortunately, there is no recognized screening procedure to identify patients that are at risk for arterial stroke.

The availability and nature of other treatment options.

Other treatment options may include self-administered, over-the counter analgesics and rest
medical care and prescription drugs such as anti-inflammatory, muscles relaxants, and pain killers
hospitalizations
spinal injections/trigger point injections/Botox injections
surgery

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If you chose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated.

Remaining untreated may allow the formation of adhesions and reduce mobility of your joints and muscles. This may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

_____ Doctor's initial if applicable for this patient.

Additional risk for patients with a significant intervertebral disc and/or nerve root involvement.

As explained by your Doctor, you have a risk of neurological compromise. This would consist of pressure from your involved intervertebral disc/spondylosis on your spinal cord, cauda equina, or nerve root. This will be monitored in our office by neurological examinations, possible ongoing imaging, and possible electrodiagnostic studies. We often co-manage patients with this risk with a pain management physician, neurologist, or neurosurgeon. These referrals may be suggested to you.

If these referrals, updated imaging, or electrodiagnostic testing are heavily recommended and you refuse; it may increase your risk of a progressive neurological compromise and possible permanent damage to your nerve roots/spinal cord, developing cauda equina syndrome, or developing the need for surgical intervention.

Consent to treatment (minor)

I hereby request and authorize _____ to perform diagnostic tests and render the above care to my minor son/daughter _____. This authorization also extends to all other doctors and office staff members.

As of this date, I have the legal right to select and authorize health care services for the minor child named above. (If applicable) Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

Waiver of Liability Relating to Coronavirus/COVID-19

The novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization. COVID-19 is reported to be extremely contagious. The state of medical knowledge is evolving, but the virus is believed to spread from person-to-person contact and/or by contact with contaminated surfaces and objects, and even possibly in the air. People reportedly can be infected and show no symptoms and therefore spread the disease. The exact methods of spread and contraction are unknown, and there is no known treatment, cure, or vaccine for COVID-19. Evidence has shown that COVID-19 can cause serious and potentially life-threatening illness and even death.

North Orlando Spine Center, LLC cannot prevent you [or your child(ren)] from becoming exposed to, contracting, or spreading COVID-19 while utilizing North Orlando Spine Center LLC's services or premises. It is not possible to prevent against the presence of the disease. Therefore, if you choose to utilize North Orlando Spine Center LLC's services and/or enter onto North Orlando Spine Center LLC's premises you may be exposing yourself to and/or increasing your risk of contracting or spreading COVID-19.

ASSUMPTION OF RISK: I have read and understood the above warning concerning COVID-19. I hereby choose to accept the risk of contracting COVID-19 for myself and/or my children in order to utilize North Orlando Spine Center LLC's services and enter North Orlando Spine Center LLC's premises. These services are of such value to me [and/or to my children,] that I accept the risk of being exposed to, contracting, and/or spreading COVID-19 in order to utilize North Orlando Spine Center LLC's services and premises in person [if applicable: "rather than arranging for an alternative method of enjoying the same services virtually (e.g. videoconference)].

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WAIVER OF LAWSUIT/LIABILITY: I hereby forever release and waive my right to bring suit against North Orlando Spine Center, LLC and its owners, officers, directors, managers, officials, trustees, agents, employees, or other representatives in connection with exposure, infection, and/or spread of COVID-19 related to utilizing North Orlando Spine Center LLC's services and premises. I understand that this waiver means I give up my right to bring any claims including for personal injuries, death, disease or property losses, or any other loss, including but not limited to claims of negligence and give up any claim I may have to seek damages, whether known or unknown, foreseen or unforeseen.

CHOICE OF LAW: I understand and agree that the law of the State of Florida will apply to this contract.

Patient initial below acknowledging and accepting risks with cupping and instrument assisted soft tissue mobilization.

_____ I understand that all treatments at this facility are therapeutic in nature. I agree to communicate to the practitioner any physical discomfort or draping issues during the session. Information has been provided to me about cupping therapy and instrument assisted soft tissue mobilization. If I choose to experience these therapies during treatments, I understand the potential effects and after-care recommendations. It has been explained to me that there are contraindications for cupping therapy. I have fully disclosed all health factors to my therapist, including those not mentioned on my health history intake form, to avoid any complications. It has been explained to me that there is the possibility of discolorations and bruising that can occur. I further understand that the discolorations and/or bruising will dissipate from a few hours to as long as 2 weeks in some cases and in relation to my after-care activities. I understand that cupping therapy and instrument assisted soft tissue mobilization should not be combined with aggressive exfoliation, 4 hours after shaving, after a sunburn or when I'm hungry or thirsty. I understand that I should avoid exposure to cold, wet, and/or windy weather conditions, hot showers, baths, saunas, hot tubs and aggressive exercise for 24 hours. It has been explained to me that exposure to such extremes can produce undesirable effects and I should avoid such situations. I understand that I should avoid caffeine, alcohol, sugary foods and drinks, dairy and processed meats and I should consume an abundance of clean water. These therapies can also cause abrasions to the skin. I agree to allow the cupping or instrument assisted soft tissue mobilization practitioner to perform the stated therapies. I also agree that I have read, understand and will follow all of the information stated above and will not hold the practitioner responsible. I will also not hold the practitioner responsible for any negative outcomes or adverse effects. For the purpose of clarification, "Practitioner" in this office refers to Physicians, Registered Chiropractic Assistants, Licensed Massage Therapists and Certified Chiropractic Physician Assistants.

I HAVE CAREFULLY READ AND FULLY UNDERSTAND ALL PROVISIONS OF THIS RELEASE, AND FREELY AND KNOWINGLY ASSUME THE RISK AND WAIVE MY RIGHTS CONCERNING LIABILITY AS DESCRIBED ABOVE

Please sign below:

I have read () or have had read to me () the above explanation of the above treatment options. I have discussed it with the Doctor or record for this date of service and have had my questions answered to my satisfaction. By signing below, I state that I have weighted the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the care recommended. Having been informed of the risks, I hereby give my consent to treatment with the understanding that the practice of chiropractic medicine is not an exact science and acknowledge that no guarantees have been made to me concerning the results of the treatment or procedure.

Dated: _____ Printed Patient's Name: _____ Signature: _____

Dated: _____ Printed Doctor's Name: _____ Signature: _____

Signature of Parent or Guardian (if a minor)

North Orlando Spine Center, LLC
2160 West SR 434, Suite 108, Longwood, FL 32779
Phone: 407-331-9913 Fax: 407-331-9918

Records Reviewed on

By North Orlando Spine Center, LLC



North Orlando Spine Center, LLC

Team-Based Chiropractic & Rehabilitation Solutions

Dr. Nicole Ingrand
Dr. Amanda Connelly
Dr. Aaron Proctor
Dr. Adam Sproat
Dr. Melanie Milner

QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name _____

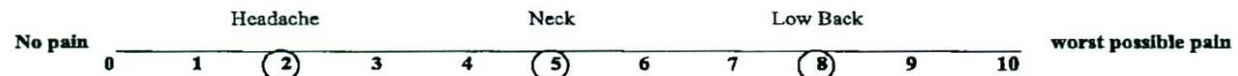
Date _____

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.

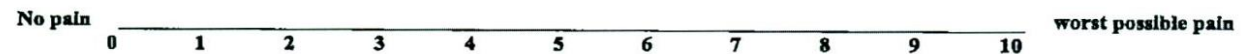
Example:



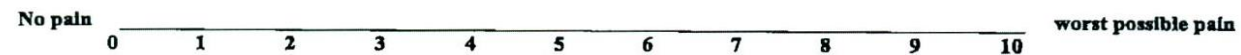
1 – What is your pain RIGHT NOW?



2 – What is your TYPICAL or AVERAGE pain?



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



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



OTHER COMMENTS:

Examiner _____

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