Dr. Nicole Ingrando
Dr. Amanda Connelly
Dr. Aaron Proctor

North Orlando Spine Center, LLC

Chiropractic and Rehabilitation

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: **S**ingle **M**arried **O**ther

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? **Y**ES / **N**O 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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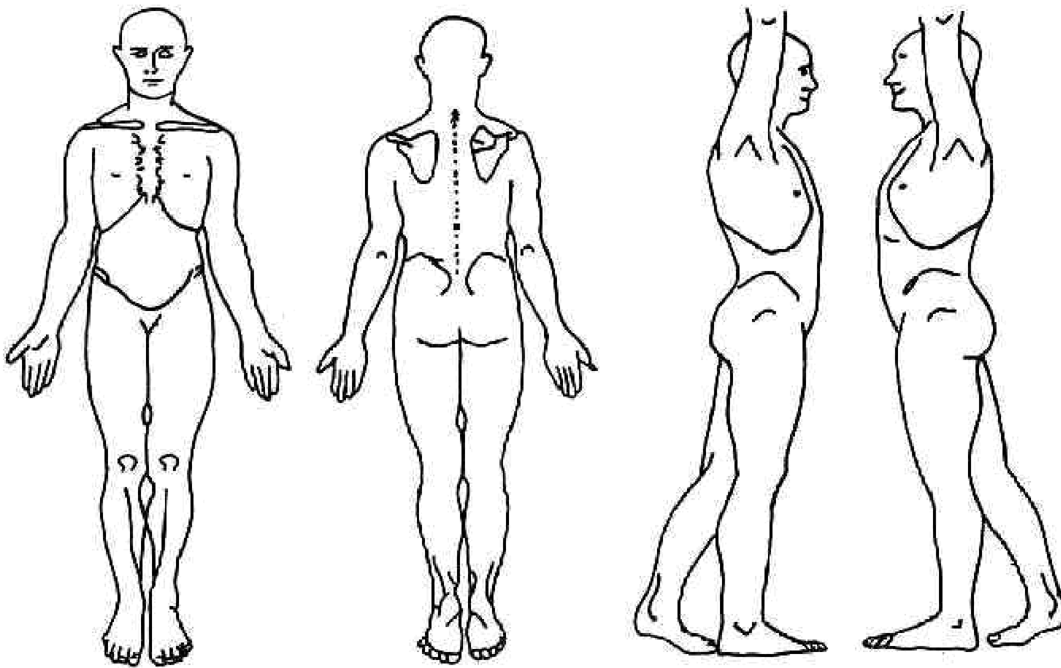
Patient Name: ____ Date: _______/______/________

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 ___________

Surgeries:

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

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Patient Name: ____

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) Heroine (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? _________

Patient Name:

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

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
Cardiovascular			
Poor Circulation			
High Blood Pressure			
Aortic Aneurism			
Heart Disease			
Vascular Disease			
Heart Attack			
Chest Pain			
High Cholesterol			
Pace Maker			
Jaw Pain			
Irregular Heartbeat			
Swelling of Legs			
Genitourinary			
Kidney Disease			
Lower Side Pain			
Burning Urination			
Blood in Urine			
Kidney Stone			
Hematological/Lymph			
Hepatitis			
Blood Clots			
Cancer			
Easy Bruising			
Easy Bleeding			
Ever/Sweats/Chills			
Respiratory			
Asthma			
Tuberculosis			
Shortness of Breath			
Emphysema			
Cold/Flu			
Coughing/Wheezing			
Ear/Nose/Throat			
Dizziness			
Hearing Loss			
Sinus Infection			
Nose Bleed			
Sore Throat			
Difficulty Swallowing			
Bleeding Gums			

	Present	Past	N/A
Integumentary			
Skin Lesions			
Skin Ulcers			
Skin Disease			
Eczema			
Psoriasis			
Rashes			
Allergic/Immune			
Hives			
Immune Disorder			
HIV/AIDS			
Allergy Shots			
Cortisone Use			
Gastrointestinal			
Gallbladder Problems			
Bowel Problems			
Constipation			
Liver Problems			
Ulcers			
Diarrhea			
Nausea/Vomiting			
Bloody Stools			
Poor Appetite			
Musculoskeletal			
Gout			
Arthritis			
Joint Stiffness			
Muscle Weakness			
Osteoporosis			
Broken Bones			
Joints Replaced			
Endocrine			
Thyroid Disease			
Diabetes			
Hair Loss			
Menopause			
Menstrual Problems			
Psychiatric			
Depression			
Anxiety Disorder			
Unusual Stress			
Weight Loss/Gain			

	Present	Past	N/A
Eyes			
Glaucoma			
Double Vison			
Blurred Vision			
Neurological			
Stroke			
Seizures			
Head Injury			
Brain Aneurysm			
Numbness			
Severe Headaches			
Pinched Nerves			
Parkinson’s			
Carpal Tunnel			

Comments:

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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:** _______________

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Assignment of Benefits

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 pursing 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 CERTIFCATION — 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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Chiropractic and Rehabilitation

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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 understands 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 hand held 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 hand held tool. We may prescribed 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 feels 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 permeant 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.

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)

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