North Orlando
Spine Center, LLC
Team-Based Chiropractic & Rehabilitation Solutions

Nicole Ingrando, D.C
Amanda Connelly, D.C
Aaron Proctor, D.C
Adam Sproat, D.C
Juliana Mitchell, D.C

Patient Information

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

How would you like us to refer to you/preferred name? _____

Home Phone _____ Cell _____ Work _____

Address _____City _____State (abr.) ____ Zip_____

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

Social Security # _____-_____-_____ Marital Status: **S**ingle **M**arried **O**ther

Occupation: _____ Employer Name: _____

Who is your Medical Doctor? _____ OB/GYN_____

Were you in an accident? (If applicable)

Is your condition related to a work place or auto accident? ☐ Auto ☐ Work Date of Accident:_____/_____/_____

Do you have an attorney? ☐ YES ☐ NO Law Firm: _____

Attorney Name: _____ Email/Phone Number: _____

Auto Insurer: _____ Claim Number: _____

Do you have Health Insurance? (If applicable)

Name of Insurer:_____ Member ID: _____

Group Number: _____ Are you enrolled in Medicare? _____

Patient Signature _____ Date _____/_____/_____

Parent/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.

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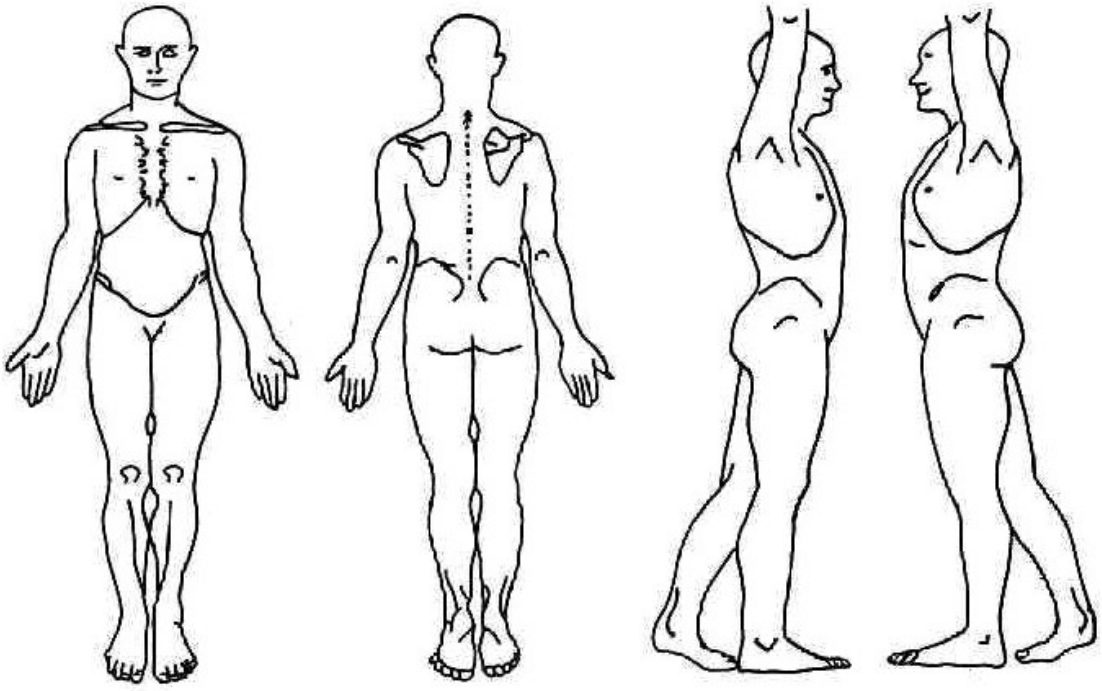
Health History

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

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



your symptoms below: _____

_____

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

_____

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

North Orlando Spine Center, LLC
2170 West SR 434, Suite 252, Longwood, FL 32779
Phone: 407-331-9913 Fax: 407-331-9918
info@northorlandospine.com

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Have you had any Surgeries:

Surgery :	Year:

Social History - How often do you:

Consume Caffeine		Never		Occasionally		Often
Drink Alcohol		Never		Occasionally		Often
Illicit Substance Use		Never		Occasionally		Often
Exercise		Never		Occasionally		Often
Experience Stress		Never		Occasionally		Often
Wear a seatbelt		Never		Usually		Always
Smoking Status/History		Never Smoker		Former Smoker		Current Smoker

Family History: (Check all that apply)

	Mother	Father	Brother	Sister	Grandmother	Grandfather
Arthritis						
Cancer						
Cholesterol						
Diabetes						
Heart Problems						
High Blood Pressure						
Psychiatric						
Stroke						
Thyroid						

Is your mother still living?		Yes		No	If no, what was her cause of death?	
Is your father still living?		Yes		No	If no, what was his cause of death?	
Are your siblings still living?		Yes		No	If no, please indicate which sibling and cause of death	

Children

Do you have any children? How many?	

Occupational Activities:

	Administration		Computer User		Manual Labor		Daycare/Childcare		Healthcare
	Construction		Student		Athlete		None		Other

Are you:		Left Handed		Right Handed	

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Allergies:

Please list any allergies or sensitivities

Current Medications:

Please List Medications You Take:	**Dosage:**

ADDITIONAL QUESTIONS

	Yes	**No**
Do you have problems with recurring headaches?		
Have you lost weight without trying?		
Have you gained weight and are having problems losing it?		
Does your pain wake you at night?		
Have you had a change in bowel or bladder habits?		
Have you recently had any unusual bleeding or discharge?		
Do you have thickening/lump in the breast or anywhere else?		
Do you have a nagging cough or hoarseness?		

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Review of Systems

	Pres-ent	Past	N/A		Pres-ent	Past	N/A		Pres-ent	Past	N/A
Cardiovascular				**Genitourinary**				**Musculoskeletal**			
Poor Circulation				Kidney Disease				Arthritis			
High Blood Pressure				Lower Side Pain				Joint Stiffness			
Aneurysm				Burning Urination				Muscle Weakness			
Heart Disease				Blood in Urine				Osteoporosis			
Vascular Disease				Kidney Stone				Broken Bones			
Heart Attack				**Integumentary**				Muscle Spasms			
Chest Pain				Skin Lesions				**Endocrine**			
High Cholesterol				Skin Ulcers				Thyroid Disease			
Pacemaker				Skin Disease				Hair Loss			
Jaw Pain				Eczema				Diabetes			
Irregular Heartbeat				Psoriasis				Menopause			
Swelling of Legs				Rashes				Menstrual Problems			
Neurological				**Gastrointestinal**				**Pscychiatric**			
Stroke				Gallbladder Problems				Depression			
Seizures				Bowel Problems				Anxiety Disorder			
Head Injury				Constipation				Unusual Stress			
Aneurysm				Diarrhea				**Ear/Nose/Throat**			
Severe Headaches				Ulcers				Dizziness			
Parkinsons				Liver Problems				Hearing Loss			
Respiratory				Nausea/Vomiting				Sinus Infection			
Asthma				Bloody Stools				Nosebleed			
Tuberculosis				Poor Appetitie				Sore Throat			
Shortness of Breath				**Eyes**				Difficulty Swallowing			
Emphysema				Glaucoma				Bleeding Gums			
Cold/Flu				Double Vision				**Other:**			
Coughing				Blurred Vision							
Wheezing				**Allergic/Immune**							
Hematological/Lymph				Hives							
Hepatitis				Immune Disorder							
Blood Clots				HIV/Aids							
Cancer				Allergy Shots							
Easy Bruising				Cortisone Use							
Easy Bleeding											
Fever/Sweats/Chills											

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Patient Name: _____ Date: _____

I certify that I'm the patient or legal guardian listed above. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of any needed information by this office. I authorize this office and its staff to examine and treat my condition as the doctors see fit. I hereby authorize this office to release all information necessary to any insurance company, attorney, adjuster or collection agency for the purpose of claim reimbursement of charges or other charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I'm responsible for timely payment of such services. 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 and agree to pay for services as the charges are incurred. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.

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 treatment being rendered. I (we) authorize this office 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 or for the purpose of approvals and authorizations. 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 this office as payment toward the total charges for professional services rendered. I (we) further authorize North Orlando Spine Center, LLC to submit any and all personal information deemed necessary to collection agencies of its choosing in order to collect payment in the event of non-payment or unpaid balances and this applies to hiring collection agencies to recover unpaid balances or transferring the rights to unpaid balances to collection agencies.

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, North Orlando Spine Center, LLC. 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 attorney's 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.

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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 North Orlando Spine Center, LLC and its providers to: furnish an insurer, an insurer's intermediary, my other medical providers and my attorney(s) via mail, facsimile or e-mail and by any other communications method, 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. I also consent to allow North Orlando Spine Center, LLC to use any type of communication necessary to contact me about any question or concern about my treatment(s) or appointments. The lines of communication are as follows but are not limited to, phone calls, voicemails, emails, text messages, faxes or any other communication devices. I authorize North Orlando Spine Center to release any and all information necessary to third parties in order to facilitate business activities. This includes but is not limited to scheduling services, software companies, appointment reminder services, transportation services and collections agencies.

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.

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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.

Informed Consent

Please read this section in its entirety to understand the treatments provided at North Orlando Spine Center, LLC and the potential risks associated with the treatments. Every medical procedure does carry risks to some degree, and we have made every attempt to list these risks in order to inform our patients of these risks. We have made an extensive attempt to list the risks of treatment at our office although other unpredicted and unknown adverse events and complications are possible. The physicians will make every reasonable effort during the examination to screen for contraindications to care. It is your responsibility to inform the physician of your entire medical history even if it does not seem pertinent for what you are coming into the office for. Some patients will feel some stiffness and soreness and possibly aggravation of symptoms following the first few days of treatment and throughout the care plan and this is typically normal.

Treatments and Procedures Provided at Our Office Along with Associated Risks:

Examination/s: As a patient or prospective patient, you consent to have examination/s performed. These are required in order to diagnose your condition and also assist in monitoring progress and updating diagnoses and management plans. Examinations consist of multiple elements performed by the physician as deemed indicated and other office staff members may assist during the process. These elements include history taking, vital signs, auscultation, palpation, neurological evaluation, range of motion testing, orthopedic exams, postural analysis and visual inspection as well as any other methods of testing that are deemed indicated at the time of examination. You also consent to additional tests being ordered out of the office as deemed indicated by the physician such as X-Ray, MRI and Blood Labs among other possible tests. You also consent to referrals being made to other health care providers as deemed indicated by the physician. Additionally, although we don't perform pelvis exams in the sense of evaluating genitalia or rectal regions, other parts of the pelvis will possibly be evaluated which may be in close proximity or immediately adjacent to those regions depending upon your presenting complaint such as the hips, gluteal musculature, upper thighs, groin regions, lower abdomen and lower back.

Manual Therapy and Massage: The physicians or therapists may use their hands, tools (such as instrument assisted soft tissue mobilization, cupping and vibration), and forms of electrical stimulation to decrease or loosen myofascial adhesions and musculoskeletal tightness as well as to reduce inflammation and pain.

Therapeutic Exercise/Stretching: The physicians or therapists may provide passive stretching and/or have you participate in active stretching to improve range of motion of muscles and joints as well as to reduce pain. Furthermore, traction or decompression types of stretching may be administered. Sometimes tools such as instrument assisted soft tissue mobilization instruments and devices such as electrical stimulation are used to assist with stretching. We may prescribe active rehabilitative care to be completed in the office or at home or an exercise facility to improve range of motion of muscles and joints as well as to strengthen the respective areas of your body.

Neuromuscular re-education/Unlisted Therapeutic Procedures: The physician or therapist may provide a treatment of a joint/s and muscle group or body region performed with active and/or passive movement with simultaneous stimulation such as with Instrument Assisted Soft Tissue Mobilization, vibration, electrical stimulation or application of Kinesiology Tape in an effort to improve the stability of the region, improve the postural neutral position, alter the muscle memory, and/or decrease tightness and pain.

- Risks Associated with Manual Therapy, Massage, Therapeutic Exercise/Stretching and Neuromuscular Re-education/Unlisted Therapeutic Procedures: There are moderate risks of soreness and redness of the treated area. There is a mild to moderate risk of bruising and abrasions of the treated tissues. There is a mild risk of muscular strain and ligamentous sprain as well as burns. There is a mild risk of aggravating symptoms and complaints. There is a trace risk of dislocation of joints in the regions treated as well as fractures, cervical myelopathy and intervertebral disc injuries in the treated regions.

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Therapeutic Ultrasound: The physicians or therapists may administer this procedure which consists of an ultrasound probe with ultrasound gel on an affected body part in order to decrease inflammation, swelling and pain.

- Risks: There are mild risks of soreness and redness of the treated area. There is a mild risk of bruising and abrasions of the treated tissues. There is a mild risk of muscular strain and ligamentous sprain as well as burns. There is a mild risk of injury to the bone/s of the treated area in the form of burns, bruising, inflammation and otherwise worsening of existing bone conditions that may or may not be known/diagnosed. The existing bone conditions that it would possibly worsen are those with loss of integrity such as fracture or pathologic processes such as metastasis.

Electrical Stimulation: The physicians or therapists may use electrical stimulation in the form of applying an electrical current through pads that are connected to your body or by using other stimulation devices.

- Risks: There are mild risks of soreness and redness to the treated area as well as with localized burns. Furthermore, there is a significant risk of causing interference or malfunctioning of implanted or attached electrical devices such as pacemakers among other devices.

Kinesiology Taping: The physicians or therapists may apply kinesiology tape to treated body parts to optimize pain free movement, minimize pain and to decrease inflammation and swelling.

- Risks: There is a risk of allergic reaction to the components of the Kinesiology Tape applied as well as with tissue prep supplies such as rubbing alcohol. The components of Kinesiology tape may vary but common allergens contained may include latex and adhesives. It is not advised to have regions of the body with Kinesiology tape applied directly exposed to sunlight for more than briefly due to the risk of interactions with the adhesives of the tape which can cause reactions to the skin such as burns. Furthermore, there is a mild risk of the kinesiology tape irritating the tissue below the tape as well as the edges of the tape irritating the contacted tissue at the edges. Upon removal of the Kinesiology Tape, a layer of adhesive may be left behind which can require extensive tissue cleaning to remove. Removal of the tape is recommended by using either bandage removal products or by soap and water. The tape should be removed slowly and not by “ripping” it off.

Hot/Cold Therapy: The physicians and therapists may utilize ice packs on the affected regions to reduce inflammation, swelling and pain. Heating pads may be used on the affected regions to reduce pain, increase circulation, and reduce inflammation and swelling as well as to improve mobility. Therapeutic ultrasound may be used on affected regions to provide heat in order to decrease inflammation and swelling as well as to improve mobility and decrease pain.

- Risks: There is a mild risk of burn injuries from using heat therapies. There is a mild risk of cold injuries from using cold/ice therapies. Appropriate measures are taken to minimize these risks such as using layers of protective barriers between the heat and cold packs and the tissue being treated. Appropriate measures are taken with ultrasound to minimize the risk of bone injuries by keeping the probe moving and/or by using a non-continuous duty cycle setting as well as using appropriate settings. Furthermore, some people may become locally inflamed or have adverse responses to care with hot and cold therapies.

Electrical Therapies: All therapies that include electrical devices being used on/with a patient such as electrical stimulation, vibration and ultrasound carry a significant risk with causing interference or malfunctioning of implanted or attached electrical devices such as pacemakers among other devices. Please inform the provider and therapist if you have any electrical implanted or attached devices so either the therapy can be avoided or modified.

Chiropractic Adjustment/Manipulation: The physicians may administer this procedure to you with their hands or an instrument to provide force into a joint or multiple joints to improve the mobility of a single joint or multiple joints.

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- Risks: There is a moderate risk of being sore following an adjustment. Adjustments carry a mild risk of causing intervertebral disc injuries, bruising, muscle strain and ligamentous sprain. Adjustments carry a very low risk of causing fractures, dislocations and cervical myelopathy. Another rare but important risk to acknowledge regarding cervical spine (neck) adjustments/manipulation is that these procedures have been associated with injuries to the arteries in the neck which can lead to severe complications such as dissection of an artery and stroke. Fractures are also rare occurrences and generally result from an underlying weakness of the bone such as existing fractures or metastasis which we screen for during the exam and any tests that are felt to be indicated such as X-Ray or MRI among others. The most likely location for a fracture to occur is at the rib cage. The risk for fracture is very low but does exist with chiropractic manipulation as well as with other manual therapies and stretching.

Other Treatment Options

Below are other treatment options that you may pursue outside of treating at our office with the above therapies. Risks and expected outcomes should be addressed with those respective providers. Other treatment options may include:
Treating with your primary care physician which often consists of medicine to treat complaints.
Treating with an orthopedist, which often consists of medicine, injections or surgery to treat complaints.
Treating with a neurosurgeon, which often consists of treating with surgery to treat complaints although they often use injections and medicine as well.
Treating with pain management, which often consists of treating with medicine, injections as well as other options.
Treating at a physical therapy office, which primarily consists of treating with rehabilitative exercise and stretching.
Treatment with an occupational therapist to help you adapt to your condition, resume, and maintain activities and reach goals.
Over the counter medicine and supplements.
Treating with acupuncture. This is also performed at this office. This often consists of treatments such as the insertion of needles, electrical stimulation, moxibustion, cupping and herbs being recommended.

"Do Nothing" Option and Not Treating In Accordance With Recommendations

There are risks and dangers of remaining untreated or not treating in accordance to the recommendations provided to you by your provider. Conditions remaining untreated or not treated in accordance with provided recommendations may worsen, lead to other complications with your condition/s and health and may lead to other conditions and complications. Furthermore, over time this "do nothing" process or not treating in accordance with provided recommendations may complicate pursued treatment making it more difficult and less effective at reaching desired outcomes.

Other Health Condition Interactions

Treatment at our office may interact with other health conditions. Examples include but are not limited to: increased risk of bruising with individuals taking blood thinners or that have clotting disorders; feeling ill if an individual's blood sugar is unregulated. It is important to discuss with your doctor at this office your entire health history to minimize risks of interactions. It is also advisable to speak with your primary care regarding the risks and limitations you may have in relation to your known medical conditions and medications you take.

Updates to Diagnosis and Management Plan

Your doctor at this office will update your diagnoses and management plan on an ongoing basis as indicated.

Discussion of Informed Consent with Your Doctor

Your doctor will further discuss with you in person your medical condition/s, prognosis, recommended care and risks with care as well as risks with not receiving care. This discussion will be tailored for your individual situation with all of the appropriate/known context applied. You may at any time deny consent for any procedure at our office and you may do this at any time verbally with your doctor, therapist, or other staff members. Once you agree to have procedures or treatment performed, you are acknowledging that all your questions have been properly answered, you have disclosed all your health history as well as you understand your medical condition/s and the risks of care and the risks with not receiving care. Furthermore, you acknowledge that you understand after care recommendations, and you acknowledge that you are providing informed consent to examination and treatment at this office.

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Consent to treatment of minor (If the patient is a minor)

By signing this form, I hereby request and authorize the physicians and therapists at North Orlando Spine Center, LLC to perform diagnostic tests and render the above care to my minor son or daughter. This authorization also extends to all other doctors, therapists and office staff members of North Orlando Spine Center, LLC. As of the date on this form, I have the legal right to select and authorize health care services for the minor or child I am seeking treatment for. (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 select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

By signing this form, I agree to communicate to the practitioner any physical discomfort, feelings of being uncomfortable or draping issues during the session. I further understand that the discolorations, abrasions and/or bruising should dissipate from a few hours to as long as two weeks in some cases and in relation to my after-care activities. I understand that potentially abrasive therapies such as cupping therapy and instrument assisted soft tissue mobilization should not be combined with aggressive exfoliation, four hours after shaving, after sunburn or when I am hungry or thirsty. If abrasions of the skin or breaking of the skin exists, I should keep it clean and protected until it heals and monitor for signs of infection. I attest that I am not on a special diet and that I am not in a fasting state. During the day of treatment, I should avoid alcohol, sugary foods and I should consume plenty of water. I agree to allow the doctor or other office staff to perform the above procedures. I also agree that I have read, understand, and will follow all of the information stated above. I will not hold the doctor or other staff members responsible for any negative outcomes or adverse effects associated with my treatment. For the purpose of clarification, "Practitioner" refers to any person participating in treatment at this office and refers to Doctors of Chiropractic, Registered Chiropractic Assistants, Licensed Massage Therapists, and Certified Chiropractic Assistants, Interns from a Chiropractic College or other office staff members.

NOSC Cancelation & Missed Appointment Policy

We require a minimum of 24 hours' notice when canceling or changing an appointment to avoid a cancelation fee. This allows the office time to try and fill the spot you have left vacant and offer more patients in pain a chance at care. Any appointment missed without notice will incur an automatic fee. Our cancellation fee may range from $25 - $125 depending on the appointment length. The 24-hour notice must be given Monday-Friday). If you are canceling for Monday at 9am, you need to give notice by Friday at 9am. If you are canceling for Wednesday at 2:00pm, you must give notice by Tuesday at 2:00pm. If the office is closed for a holiday, notice must be given on the prior business weekday. Cancelations must be made by phone; not voicemail, email, or SMS.

We may waive a missed appointment fee once every six months for an emergency or being sick. A fee may also be waived if a family member is able to take your appointment. Waiving additional fees may be considered with a doctor's note for being sick. Meaning if you could not make your appointment and provide a note from the ED or Urgent Care, NOSC will evaluate and consider waiving an additional fee. We provide a courtesy messaging system, however in the event a message is not sent or received the cancelation policy still applies. We encourage patients to calendarize all appointments. Our front desk team is always happy to provide you with a list of your appointments upon request to assist you.

NOSC reserves the right to refuse to schedule future appointments and/or to cancel existing appointments for a patient that has not paid their cancellation fee/s. NOSC reserves the right to require payment up front in full for appointments when a patient develops a pattern of multiple cancellations or missed appointments. If your life needs flexibility with scheduling, this may be the best option for you. You may cancel as often and whenever you like, but your payment for the appointment will not be refundable if you cancel in less than 24 hours as detailed above.

As a small independent business, we appreciate your consideration when needing to change an appointment in giving as much notice as possible.

North Orlando
Spine Center, LLC
Team-Based Chiropractic & Rehabilitation Solutions

Nicole Ingrando, D.C
Amanda Connelly, D.C
Aaron Proctor, D.C
Adam Sproat, D.C
Juliana Mitchell, D.C

Certification

I, the undersigned patient/ insured, certify that: I have read and agree to the above and freely and knowingly assume the risk and waive my rights concerning liability as described above; I have not been solicited or promised anything in exchange for receiving health care from this company or the health care providers within; 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.

Patient Name:_____ Patient Signature: _____ Date: _____

Physician Name:_____ Physician Signature: _____ Date:_____

Signature of parent/guardian if patient is a minor: _____

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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:

Headache Neck Low Back

No pain 0 1 (2) 3 4 (5) 6 7 (8) 9 10 **worst possible pain**

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1 – What is your pain RIGHT NOW?

No pain 0 1 2 3 4 5 6 7 8 9 10 **worst possible pain**

2 – What is your TYPICAL or AVERAGE pain?

No pain 0 1 2 3 4 5 6 7 8 9 10 **worst possible pain**

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

No pain 0 1 2 3 4 5 6 7 8 9 10 **worst possible pain**

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

No pain 0 1 2 3 4 5 6 7 8 9 10 **worst possible pain**

OTHER COMMENTS:

_____

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_____
Examiner

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