PATIENT INFORMATION

Date _____

Patient _____

Email Address _____

Address _____

City _____ State _____ Zip _____

Sex: ❑ M ❑ F Age _____ Birthdate _____Race_____

Ethnicity_____ Primary Language_____

❑ Single ❑ Married ❑ Widowed ❑ Divorced, Living with _____

Social Security # _____-_____-_____

Occupation _____

Employer _____

Employer Phone _____

Spouse's Name _____

Spouse's Birthdate _____SS# _____

❑ I wish to receive a copy of my clinical summary after each visit

Seasonal Address Information

If you reside at a second address during part of the year, please provide the information below:

Second Address:_____

City Sate Zip _____

O Jan O Feb O Mar O Apr O May O Jun O Jul O Aug O Sep O Oct O Nov O Dec

Home _____

PHONE NUMBERS

Cell _____

Work _____ Ext. _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT:

Name _____ Relationship _____

Contact Phone _____ Ext. _____

PREGNANCY DISCLAIMER

Women: Is there any chance that you are pregnant?
_____ Yes , I am _____months pregnant
_____ No

INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Primary Insurance Co. _____

Subscriber's Name _____

Subscriber Birthdate, if not pt. _____ SS#_____

Relationship to Patient _____

Group/ID # _____

Is patient covered by additional insurance? ❑ Yes ❑ No

Insurance Co. _____

Group/ID # _____

Subscriber's Name _____

Subscriber Birthdate, if not pt. _____SS#_____

Relationship to Patient _____

ASSIGNMENT AND RELEASE/ AUTHORIZED SIGNATURE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Accurate Chiropractic Clinic all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the release of any medical information necessary to process this claim and request payment of insurance benefits either to myself or to the party who signs below. I authorize the use of this signature on all insurance submissions.

_____
Responsible Party Signature

_____ _____
Relationship Date

ACCIDENT INFORMATION

Is condition due to an accident? ❑ Yes ❑ No Date _____

Type of accident: ❑ Auto ❑ Work ❑ Home ❑ Other

To whom have you made a report of your accident?

❑ Auto Insurance ❑ Employer ❑ Worker Comp. ❑ Other

Are you currently out of work due to the accident? ❑ Yes ❑ No

Dates out of work _____-_____

Please provide the receptionist a copy of the police report and any images of the accident including vehicle damage.

Please be sure to give the receptionist a copy of your Insurance Card(s) and Drivers license or PhotoID

_____ _____ _____ _____
Patient Signature Date Witnessed By Date

Patient Name:_____

Cancellation and Missed Appointment Policy

Our goal is to provide quality, individualized, chiropractic care in a timely manner. “No-shows” and late cancellations inconvenience those individuals who need access to care. We would like to notify you of our office policy regarding missed appointments. This policy enables us to better utilize available appointments for our patients in need of medical care.

Cancellation of an Appointment

In order to be respectful of the needs of other patients, please be courteous and call Accurate Chiropractic Clinic promptly if you are unable to show up for an appointment. This time will be reallocated to someone who is in need of treatment. If it is necessary to cancel your scheduled appointment, **we require that you call at least 24 hours in advance**. Appointments are in high demand, and your early cancellation will give another person the possibility to have access to timely chiropractic care.

How to Cancel Your Appointment

To cancel appointments, please call 352-684-2707.

Multiple Missed Appointments

Multiple missed appointments will have a negative effect on your progress. If you find yourself habitually cancelling your appointments, or consistently stressed about making it on-time, please ask to speak with our patient coordinator so that you can be properly rescheduled.

No Show or Late Cancellation Policy

A "no-show" or “late cancellation” is someone who misses an appointment without cancelling it within 24 hours. A failure to be present at the time of a scheduled appointment will be recorded in your medical record as a "no-show".

• First missed appointment: there will be no charge

• Second and Additional missed appointments: $25.00 fee will assessed to your account. This fee is not covered by insurance.

By signing below, I attest that I have read and understand the above cancellation and missed appointment policy.

_____ _____

Patient Signature Date

CURRENT SYMPTOM LIST

Date: _____

Name:_____

Activities of Daily Living: Check all the activities that you are unable to do or have difficulty with because of this problem.

❑ Sitting ❒ Standing ❑ Lifting
❑ Moving Arms ❑ Moving legs
❑ Bending at waist ❑ Carrying
❑ Lying/sleeping ❑ Pulling
❑ Pushing ❑ Kneeling ❑ Twisting or turning back ❑ Twisting or turning neck ❑ Turning over
❑ Reaching ❑ Grooming ❑ Dressing ❑ Bathing ❑ Going to the bathroom ❑ Recreational activities
❑ Golfing ❑ Sexual relations
❑ Going up/down stairs
❑ Household chores/Housework
❑ Cough/sneeze ❑ Riding in car

HEAD:

_____Headaches
_____a. migraine in nature
_____b. back of Head
_____c. sinus (allergy)
_____d. temples
_____e. entire head
Frequency _____ x's per _____
_____ Head feels heavy
_____ Lightheadedness
_____ Fainting
_____ Eye Strain
_____ Light bothers eyes
_____ Blurred vision
_____ Double vision
_____ Dizziness
_____ Pain in the ears
_____ Ringing/buzzing in the ear/s
_____ Sinus trouble
_____ Jaw pain/clicking
_____ Pain Scale

MID-BACK:

_____Mid-back pain
_____Mid-back stiffness
_____Muscle spasms in mid-back
_____Pain in kidney area
_____Pain Scale

NECK:

_____ Neck pain
_____ Neck stiffness
_____ Neck pain with movement
____ forward
____ backward
____ turning to the left
____ turning to the right
____ bending to the left
____ bending to the right
_____ Muscle spasms in neck
_____ Grinding sounds in the neck
_____ Arthritis in the neck
_____ Pain Scale

SHOULDERS:

_____ Pain in the joint ❑ L ❑ R
_____ Pain across the shoulders
_____ Pain between shoulder blades
_____ Stiffness in shoulder ❑L ❑ R
_____ Tension in the shoulders
_____ Muscle spasms ❑ L ❑ R
_____ Unable to raise arm over head/over shoulder level
_____ Pain Scale

ARMS & HANDS:

_____ Pain in the upper arm ❑ L ❑ R
_____ Pain in the elbow ❑ L ❑ R
_____ Tennis elbow ❑ L ❑ R
_____ Pain in forearm ❑ L ❑ R
_____ Pain in hands ❑ L ❑ R
_____ Pain in fingers ❑ L ❑ R
_____Sensation of pins and needles in Arms ❑ L ❑ R
_____Sensation of pins and needles in fingers ❑ L ❑ R
_____Numbness in arms ❑ L ❑ R
_____Numbness in hands ❑ L ❑ R
_____Fingers go to sleep ❑ L ❑ R
_____Stiffness in fingers ❑ L ❑ R
_____Hands get cold ❑ L ❑ R
_____Swollen joints in fingers
_____Loss of grip strength ❑ L ❑ R
_____ Pain Scale

LOW BACK:

_____Low back pain and stiffness
_____Low back pain
_____Low back stiffness
_____Muscle spasms in low back
_____ Pain Scale

HIPS, LEGS & FEET

_____Pain in the buttocks ❑ L ❑ R
_____Pain in the hip joint ❑ L ❑ R
_____Pain down both leg
_____Pain down one leg ❑ L ❑ R
_____Leg cramps ❑ L ❑ R
_____Knee pain ❑ L ❑ R
_____ inside ❑ L ❑ R
_____outside ❑ L ❑ R
_____Pins & needles in legs ❑ L ❑ R
_____Numbness in legs ❑ L ❑ R
_____Numbness in feet ❑ L ❑ R
_____Numbness in toes ❑ L ❑ R
_____Swollen ankles ❑ L ❑ R
_____Swollen feet ❑ L ❑ R
_____Feet feel cold
_____ Pain Scale

GENERAL

_____Anxiety
_____Nervousness
_____Depression
_____Fatigue
_____Generally feel run down
_____Loss of weight _____lbs
_____Gain weight _____lbs

Women Only:

_____Menstrual cramping
_____Irregular periods
_____Vaginal discharge
_____Vaginal bleeding
_____Breast pain
_____Lumps on the breast

Men Only:

_____Urinary frequency
_____Difficulty in starting urination
_____Night urination
_____Painful urination
_____Prostate swelling/pain
_____Bladder trouble

All patients require spinal x-rays and/or specialized imaging in their areas of complaint prior to obtaining spinal adjustments.

PAST HEALTH HISTORY

Name _____ **Date** _____

Please list any accidents or falls and the date of the incident: Car Accidents: _____

Falls: _____ Sports: _____ Other: _____

List any broken bones (fractures) or dislocations: _____

Are you being treated for any other conditions that you have not told us about? _____

Date of last physical exam: _____ Primary Care Physicians Name: _____

PATIENT CONDITION

Main Complaint:_____

When did your symptoms appear? _____

Is this condition getting progressively worse? ❑ Yes ❑ No ❑ Unknown

What treatment **have you already received** for your current condition? (*circle all that pertain*)

None Surgery Physical Therapy Chiropractic Adjustments

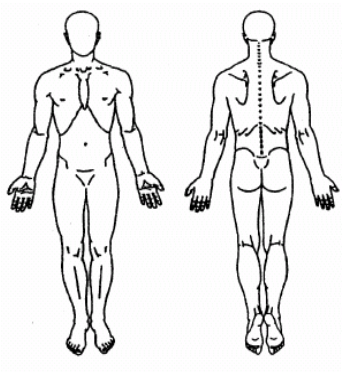
Medications Pain Management Injection Other _____

Name and phone numbers of other doctor (s) who have treated you for your condition:

_____

_____

Mark an "X" on the picture where you have pain, "N" numbness, or "T" tingling



Please list any medications or over-the-counter drugs that you are currently taking and why:

_____

_____

OPERATIONS AND PROCEDURES

DATE		**DATE**		**DATE**	
_____	Tonsillectomy	_____	Tubes in Ears	_____	Sinus
_____	Gall Bladder	_____	Kidney Stones	_____	Hernia
_____	Spinal Surgery	_____	Hysterectomy	_____	Cosmetic
_____	Other: _____	_____	Other: _____	_____	Appendectomy

❑ **I have never had any surgeries** _____

Hospitalizations _____

SOCIAL HISTORY/HABITS

Smoking	Packs/Day: _____ previous smoker? _____	**Exercise:**	_____ None	**Days per week:**	**Describe Exercise:**
Drinking	Alcohol/Week: _____		_____ Mild	1 – 2	_____
Caffeine	Cups/Day: _____		_____ Moderate	3 – 4	_____
Water	Glasses/Day: _____		_____ Active	5 – 7	_____

Sleep: **Hours per night** (circle one) 3 – 5 5 – 7 8 – 10 **Do you wake up tired?** _____ Yes _____ No

FAMILY HISTORY

	Diabetes	Heart	Kidney	Cancer	Stroke	Other	Alive	Deceased
Mother	❑	❑	❑	❑	❑	❑ _____	❒	❒
Father	❑	❑	❑	❑	❑	❑ _____	❒	❒
Brother, # of _____	❑	❑	❑	❑	❑	❑ _____	❒	❒
Sister, # of _____	❑	❑	❑	❑	❑	❑ _____	❒	❒
Children, # of _____	❑	❑	❑	❑	❑	❑ _____	❒	❒

REVIEW OF SYSTEMS

Name: _____ Date: _____

Has any other doctor/hospital taken any X-rays, MRI, CT Scans because of your present condition?

_____ Yes _____ No If Yes, When? _____ (Date) Where _____

If, x-rays, were the x-rays taken while standing? _____ Yes _____ No

REVIEW OF SYSTEMS Please check each item that applies to you ☐ Check here if none applies

Allergic / Immunologic

- ❒ Arthritic flare-up
- ❒ Eyes watering
- ❒ Weak immune system
- ❒ Asthma attack recently
- ❒ Hay fever
- ❒ Environmental allergies
- ❒ Sensitivity to dust
- ❒ Rheumatoid Arthritis
- ❒ Epstein Barr Virus
- ❒ Lymes Disease
- ❒ AIDS/HIV
- ❒ Hepatitis

Cardiovascular

- ❒ Ankle swelling
- ❒ Calf cramping
- ❒ Cold feet
- ❒ High cholesterol
- ❒ Pain in left shoulder
- ❒ Change in temperature of extremity of position
- ❒ Arm pain
- ❒ Change in color of extremity
- ❒ Elevated BP
- ❒ Leg pain at rest
- ❒ Varicosities
- ❒ Blocked arteries
- ❒ Leg edema
- ❒ Heart palpations
- ❒ Murmur _____
- ❒ Dizziness with change
- ❒ Pacemaker
- ❒ Heart Attack
- ❒ Heart Disease
- ❒ Stroke
- ❒ Transient Ishemic Attack
- ❒ Blood Thinners

Constitutional, General

- ❒ Appetite decrease
- ❒ Dizziness
- ❒ Fever
- ❒ Night sweats
- ❒ Weight loss, unintentional
- ❒ Appetite increase
- ❒ Faintness
- ❒ Malaise (general discomfort)
- ❒ Tiredness
- ❒ Weight loss, intentional
- ❒ Chills
- ❒ Fatigue
- ❒ Nausea and vomiting
- ❒ Weight gain
- ❒ Pepticular
- ❒ GERD/Heartburn
- ❒ Hernia
- ❒ Hiatal Hernia

Eyes, Ears, Nose, Mouth, Throat

- ❒ Bloody nasal discharge
- ❒ Headaches
- ❒ Abrupt visual loss
- ❒ Ringing in ears
- ❒ Loss of taste
- ❒ Dental problems
- ❒ Sinus congestion
- ❒ Eye or vision problems
- ❒ Glasses
- ❒ Loss of smell
- ❒ Ear problems
- ❒ Sore throat
- ❒ Motion sickness
- ❒ Neck pain, swelling, nodes
- ❒ Bell's Palsy

Endocrine

- ❒ Bone loss
- ❒ Dry hair
- ❒ Heat intolerance
- ❒ Hyperglycemia (high glucose levels)
- ❒ Cold intolerance
- ❒ Dry skin
- ❒ Polyuria
- ❒ Hypoglycemia (low glucose levels)
- ❒ Cuts take longer to heal
- ❒ Extreme thirst
- ❒ Weight change
- ❒ Diabetes
- ❒ Thyroid Condition

To the best of my knowledge, the questions on this for have been accurately answered. I understand that providing incorrect information can be dangerous to my (my child's) health. It is responsibility to inform the doctor's office of any changes in my (my child's) medical issues. I also authorize the healthcare staff to perform the necessary health services I (my child) may need.

I have been informed that if I am uncertain about any question on the form I should ask the doctor or a member of the office staff for assistance.

_____ _____ _____ _____

Patient Signature Date Reviewed By Date

REVIEW OF SYSTEMS

Name: _____ Date: _____

REVIEW OF SYSTEMS Please check each item that applies to you ☐ Check here if none applies

Genitourinary

- ❒ Bladder infections
- ❒ Current need for kidney dialysis
- ❒ Impotence
- ❒ Currently pregnant
- ❒ Trying to get pregnant
- ❒ Taking oral contraceptives
- ❒ Blood in urine
- ❒ Urinary frequent at night
- ❒ Discharge
- ❒ Burning with urination
- ❒ Urinary incontinence
- ❒ Sexual dysfunction
- ❒ Vaginal Infections

Hematologic, Lymphatic

- ❒ Bleeding problems
- ❒ Frequent nose bleeds
- ❒ Leg swelling
- ❒ Swollen nodes under arms
- ❒ Bleeding tendency
- ❒ Increased time to stop bleeding
- ❒ Swollen lymph nodes
- ❒ Bruise easily
- ❒ Recent sickle cell crisis
- ❒ Fluid retention

Integumentary

- ❒ Burning of skin
- ❒ Dry, scaly skin
- ❒ Pruritus (itching)
- ❒ Ulcers, where _____
- ❒ Dermatitis
- ❒ Excessive scar tissue
- ❒ Rash, petechiae
- ❒ Discoloration
- ❒ Non-healing wound
- ❒ Skin cancer

Musculoskeletal

- ❒ Arthralgia (pain in joints)
- ❒ Hip pain
- ❒ Muscle weakness
- ❒ Back pain
- ❒ Muscle pain
- ❒ Stiffness in AM
- ❒ Episodic weakness
- ❒ Muscle tenderness
- ❒ Joint swelling
- ❒ Osteoporosis
- ❒ Osteoarthritis
- ❒ Herniated Disc
- ❒ Spinal Surgery
- ❒ Osteopenia

Neurological

- ❒ Change in memory
- ❒ Forgetfulness
- ❒ Nervous problems
- ❒ Trouble with balance
- ❒ Neuro symptoms or problems
- ❒ Change in sensation
- ❒ Hyperesthesia (sensitivity to touch)
- ❒ Tremors
- ❒ Uncontrolled movements
- ❒ Confusion
- ❒ Hypersensitivity
- ❒ Numbness
- ❒ Paralysis
- ❒ Epilepsy
- ❒ Multiple Sclerosis

Psychiatric

- ❒ Agitation
- ❒ Libido decrease
- ❒ Irritability
- ❒ ADD or ADHD
- ❒ Anxious feelings
- ❒ Panic attacks
- ❒ Psychiatric difficulties
- ❒ Emotional difficulties
- ❒ Mental Health counseling with a Psychologist
- ❒ Depression
- ❒ Suicidal thoughts

Respiratory

- ❒ Breathing difficulties
- ❒ Coughing up blood
- ❒ Wheezing
- ❒ Chest pain with inspiration
- ❒ Difficulty in breathing
- ❒ Need to be upright to breath
- ❒ Shortness of breath
- ❒ Coughing up excess sputum
- ❒ Asthma
- ❒ Tuberculosis
- ❒ Pneumonia

To the best of my knowledge, the questions on this for have been accurately answered. I understand that providing incorrect information can be dangerous to my (my child's) health. It is responsibility to inform the doctor's office of any changes in my (my child's) medical issues. I also authorize the healthcare staff to perform the necessary health services I (my child) may need. I have been informed that if I am uncertain about any question on the form I should ask the doctor or a member of the office staff for assistance.

_____ _____ _____ _____

Patient Signature Date Reviewed By Date

NAME: _____ DATE: _____

DISABILITY RATING SCALE FOR PAIN

US English version of the Roland-Morris disability questionnaire from MAPI 2005
The cultural adaption process described in section 1.2 at the end of the questionnaire.

When you hurt, you may find it difficult to do some of the things you normally do.

This list contains some sentences that people have used to describe themselves when they have pain. When you read them, you may find that some stand out because they describe you today. As you read the list, think of yourself today. When you read a sentence that describes today, circle the number next to it. If the sentence does not describe you, then leave the space blank and go on to the next one. **If the pain is in an area other than your back and/or neck please write in that area. Example: Knees, Hip, shoulder.**
REMEMBER; ONLY MARK THE SENTENCE IF YOU ARE SURE THAT IT DESCRIBES YOU TODAY.

1. I stay at home most of the time because of the pain in my back/neck _____.
2. I change position frequently to try and make my back/ neck _____comfortable.
3. I walk slowly because of the pain in my back/neck _____ _____.
4. Because of pain in my back/neck_____ I am not doing any of the jobs that I usually do around the house.
5. Because of the pain in my back/neck_____ I use a handrail to get upstairs.
6. Because of the pain in my back/neck_____ I lie down to rest more often.
7. Because of pain in my back/neck_____ I have to hold on to something to get out of a reclining chair.
8. Because pain in my back/neck_____ I ask other people to do things for me.
9. I get dressed more slowly than usual because of the pain in my back/neck _____.
10. I only stand up for short periods of time because of pain in my back/neck _____.
11. Because of the pain in my back/neck _____ I try not to bend or kneel down.
12. I find it difficult to get out of a chair because of the pain in my back/neck _____.
13. My back/neck _____ hurts most of the time.
14. I find it difficult to turn over in bed because of the pain in my back/neck_____.
15. My appetite is not very good because of the pain in my back/neck_____.
16. I have trouble putting on my socks because of the pain in my back/neck_____.
17. I only walk short distances because of the pain in my back/neck_____.
18. I sleep less because of the pain in my back/neck_____.
19. Because of pain in my back/neck_____. I get dressed with help from someone else.
20. I sit down for most of the day because of the pain in my back/neck_____.
21. I avoid heavy jobs around the house because of the pain in my back/neck_____.
22. Because of pain in my back/neck _____, I am irritable and bad tempered with people.
23. Because of pain in my back/neck_____, I go upstairs more slowly than usual.
24. I stay in bed most of the time because of the pain in my back/neck_____.

☐ Check here if none applies

Signature _____Date_____

Name: _____ Date: _____

OUR FINANCIAL POLICY

I understand that health and accident insurance policies are an arrangement between the insurance company and me. I understand that the service Accurate Chiropractic provides for verification for insurance coverage is in no way a promise of payment by my insurance company. I understand that if my insurance company misquotes my benefits at the time of verification, and/or denies my claim(s) for an reason including but not limited to; missing documentation, untimely filing, lack of medical necessity, the balance of my account will be billed to me and due to Accurate Chiropractic Clinic. Direct payments made from the insurance company to the Doctor's office will be credited to my account upon receipt and any balances due will be my responsibility. I understand that the doctors office will bill my secondary insurance one time as a courtesy. If they do not pay, I am responsible for paying the office within 10 days and it is my responsibility to get reimbursement from the secondary insurance company. All services rendered to me are my personal responsibility and I agree to make payment for these services to the Doctor's office. We provide secured methods of accepting your payment at the time of treatment and as a courtesy, can keep your credit card information on file to handle any outstanding balances. I understand that if I choose to keep my credit card on file, I authorize Accurate Chiropractic to charge my account for any unpaid balances. I understand that there may be a charge for special reports, copies of medical records and paperwork, such as FMLA forms and disability reviews. I understand that this charge is not billable to my insurance company and is due prior to the completion of my request. I also understand that if I suspend or terminate my care and treatment, any fees for services rendered will be immediately due and payable. Should third party collection become necessary, I agree to pay all fees involved in collection of the account and authorize the use of all provided phone numbers including cell phones.

AUTHORIZATION AND ASSIGNMENT

In consideration of you providing care for me, I agree to the following:

1. You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred.
2. I authorize the direct payment to you of any sum I now or hereafter owe you by my attorney, out of the proceeds of any settlement of my case, and by any insurance company obligated to make payment to me or you based in whole, or in part, upon the charges made for your services.
3. In the event any insurance company obligated by contractual agreement to make payment to me, or to you, for the charges made for your services refuses to make such payment upon demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company (the name (s) of which is believed to be correctly set forth under pertinent data) and authorize you to prosecute said action either in my name as you see fit and further authorize you to compromise, settle or otherwise resolve said claim as you see fit. It is understood, however that all reasonable efforts have been made to collect the sums due from the insurance company or companies contractually obligated, you will refrain from attempt and efforts to collect the amounts owed directly from me. I understand that whatever amounts you do not collect from insurance companies proceeds, whether it be all or part of what is due, I personally owe you.
4. In addition to the above, I hereby waive the statue of limitations on collection and/or recovery in this state of Florida.
5. I further agree that this Authorization is irrevocable until all monies owed Accurate Chiropractic Clinic are paid in full.

_____

Patient signature or authorized person acting on patient's behalf

AUTHORIZATION TO RECEIVE PIP BENEFITS PAYOUT INFORMATION

I authorize and direct my personal injury carrier to send Accurate Chiropractic Clinic an accounting of payouts made under all claims submitted for payment under my policy relating to the automobile accident occurring on _____.

Patient's Signature: X_____ **Date:** _____

I have read and understand the above Financial Policy. I authorize the Doctor to examine and treat my condition as deemed appropriate through the use of Chiropractic Health Care, and I give authorization for these procedures to be performed. The amount paid to the Doctor's office for X-rays is for the examination only; the X-ray negatives will remain the property of the Doctor's office and will remain on file at the Doctor's office as long as I am a patient**. I am the responsible party for payment of any treatment received or incurred on this account.** This Doctor provides only chiropractic care and is not responsible for any pre-existing medically diagnosed conditions or for making any medical diagnosis.

Patient's/Guardians Signature: **X** _____ **Date:** _____

Witness' Signature: **X** _____ **Date:** _____

Medical Information Release

ACCURATE CHIROPRACTIC CLINIC

12082 Cortez Blvd

Brooksville, FL 34613

I, _____, authorize Accurate Chiropractic to receive copies of my
(PRINT NAME)
records/and or x-ray films and reports for the purpose of Dr. Ann. L Marra to view as part of my treatment.

This authorization is given pursuant to Florida Statute 456.057 and HIPPA regulations. I understand that Florida Statute 4566.057(10) makes it clear that any third party to whom the records are disclosed is prohibited from further disclosing any information in the medical record without the expressed written consent of the patient or the patient's legal representatives.

Patient Signature: _____

Patients Date of Birth: _____

Date: _____

Name: _____ Date: _____

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____ acknowledge that I was
(PRINT NAME)

provided with a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart for six years.

_____ _____
(Date) (Signature)

_____
(Print Name)

In addition to the allowable disclosures described in the "Notice of Privacy Practices", I specifically authorize disclosure of my protected health information to the following:

- ❑ SPOUSE ONLY Name _____
- ❑ ANY IMMEDIATE FAMILY MEMBER
- ❑ OTHER _____ Relationship _____
- ❑ OTHER _____ Relationship _____
- ❑ OTHER _____ Relationship _____

For the treatment period between _____ and _____.
(**We may release all if dates left blank**)

_____ _____
(Patient/Guardian Signature) (Date)

_____ _____
(Office Staff Witness) (Date)

THIS FORM DOES NOT EXPIRE

Accurate Chiropractic Clinic

Dr. Ann Lauren Marra ~ Dr. Phillip John Brunton
Specializing in the care and maintenance of the spine

Informed Consent to Diagnostic Services:

I hereby request and consent to the performance of chiropractic examination and diagnostic testing on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named above.

I have had the opportunity to discuss with the doctor and/or with other office personnel the purpose and benefits of the chiropractic examination and diagnostic testing. Alternatives to treatment have been reviewed.

I understand that chiropractic, is not an exact science and that therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding chiropractic treatment that I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.

I understand that I may be receiving one or more of the following treatments.
Chiropractic manipulative Adjustments, Spinal Decompression Therapy, Activator, Thompson terminal Point and Cox Flexion Distraction, Physical Therapies, Myofascial Release, Therapeutic Exercises, Laser Therapy, Graston, Diagnostic X-rays, Spinal Rehabilitative Exercises, Vitamin, Mineral and Nutrient supplement suggestions.

I understand that if my injuries are directly the result of an automobile accident. I request that you file any/and all claims to my Personal Injury Protection. I do not want any Private Health Insurance billed for services received that are directly related to the accident.

_____ _____ _____
Signature of Patient Signature of Parent/Guardian of Minor Date

Informed Consent to Chiropractic Care:

I hereby request and consent to the performance of chiropractic adjustments and spinal adjustments on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named above.

I have had the opportunity to discuss with the doctor and/or with other office personnel the purpose and benefits of the chiropractic adjustments. Alternatives to treatment have been reviewed.

Though chiropractic adjustments are usually beneficial and seldom cause any problem, I understand and am informed that there are health risks to treatment. Risks include, but are not limited to, fractures, disc injuries, strokes, dislocations and sprains.

I understand that chiropractic, is not an exact science and that therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding chiropractic treatment that I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.

I understand that I may be receiving one or more of the following treatments.
Chiropractic manipulative Adjustments, Spinal Decompression Therapy, Activator, Thompson terminal Point and Cox Flexion Distraction, Physical Therapies, Myofascial Release, Therapeutic Exercises, Laser Therapy, Graston, Diagnostic X-rays, Spinal Rehabilitative Exercises, Vitamin, Mineral and Nutrient supplement suggestions.

I understand that if my injuries are directly the result of an automobile accident. I request that you file any/and all claims to my Personal Injury Protection. I do not want any Private Health Insurance billed for services received that are directly related to the accident.

_____ _____ _____
Signature of Patient Signature of Parent/Guardian of Minor Date

Informed Consent to Chiropractic Therapy and Rehabilitation:

I hereby request and consent to the performance of spinal-decompression and other chiropractic procedures, including various modes of physical therapy, myofascial release, therapeutic exercises, laser therapy, graston on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named above.

I have had the opportunity to discuss with the doctor and/or with other office personnel the purpose and benefits the chiropractic therapy and rehabilitation treatment outlined below. Alternatives to treatment have been reviewed.

Though spinal decompression sessions are usually beneficial and seldom cause any problem, I understand and am informed that there are health risks to treatment. Risks include, but are not limited to, fractures, disc injuries, strokes, dislocations and sprains.

I understand that chiropractic, is not an exact science and that therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding chiropractic treatment that I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.

I understand that I may be receiving one or more of the following treatments.
Chiropractic manipulative Adjustments, Spinal Decompression Therapy, Activator, Thompson terminal Point and Cox Flexion Distraction, Physical Therapies, Myofascial Release, Therapeutic Exercises, Laser Therapy, Graston, Diagnostic X-rays, Spinal Rehabilitative Exercises, Vitamin, Mineral and Nutrient supplement suggestions.

I understand that if my injuries are directly the result of an automobile accident. I request that you file any/and all claims to my Personal Injury Protection. I do not want any Private Health Insurance billed for services received that are directly related to the accident.

_____ _____ _____
Signature of Patient Signature of Parent/Guardian of Minor Date

_____ _____
Signature of Doctor Date

_____ _____
Signature of Witness Date

12082 Cortez Boulevard * Brooksville, Florida * Phone: (352) 684-2707 * Fax: (352) 688-1282
www.accurate-chiro.com

INFORMED CONSENT REGARDING NUTRITIONAL AND HERBAL SUPPLEMENTS

According to the Federal Food, Drug, and Cosmetic Act, as amended, Section 201(g) (1), the term drug is defined as an "article intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease." Technically, vitamins, minerals, trace elements, amino acids, herbs, or homeopathic remedies are not classified as drugs. However, these substances can have significant effects on physiology and must be used rationally. In this office, we provide healthcare counseling and make individualized recommendations regarding use of these substances in order to upgrade the quality of foods in a patient's diet and to supply nutrition to support the physiological and bio-mechanical processes of the human body.

Although these products may also be suggested with a specific therapeutic purpose in mind, their use is chiefly designed to support to given aspects of metabolic function. Use of nutritional supplements may be safely recommended for patients already using pharmaceutical medications (drugs), but some potentially harmful interactions may occur. For this reason, it is important to keep all of your healthcare providers fully informed about all medications and nutritional supplements, herbs, or hormones you may be taking.

Sale of Nutritional Supplements at Accurate Chiropractic Clinic

You are under no obligation to purchase nutritional supplements at our clinic. As a service to you, we make nutritional supplements available in our office. We purchase these products only from manufacturers who have gained our confidence through considerable research and experience. We determine quality by considering: (1) the quality of science behind the product; (2) the quality of the ingredients themselves; (3) the quality of the manufacturing process; and (4) the synergism among product components. The brands of supplements that we carry in our facility are those that meet our high standards and tend to produce predictable results.

While these supplements may come at a higher financial cost than those found on the shelves of pharmacies or health food stores, the value must also include assurance of their purity, quality, bio availability (ability to be properly absorbed and utilized by the body), and effectiveness. The chief reason we make these products available is to ensure quality. You are not guaranteed the same level of quality when you purchase your supplements from the general marketplace. We are not suggesting that such products have no value; however, given the lack of stringent testing requirements for dietary supplements, product quality varies widely.
If you have concerns about this issue, please discuss them with our staff.

I have read and understand the above statement

Patient Signature _____ Date _____

Staff Signature _____ Date _____