NEW PATIENT PERSONAL QUESTIONNAIRE

Today's date: _____

Name: _____ Street: _____

City: _____ State: _____ Zip: _____ SSI # _____ - ____ - _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

e-mail: _____ Marital Status: _____ Spouse's Name: _____

Occupation: _____ Employer: _____

Date of Birth: (mm/dd/yyyy) _____ Age: _____ Male / Female (circle)

[redacted]

Insurance Carrier: _____ Policy No. _____

Group/claim No. _____ Name of Primary Insured: _____

Please describe your chief complaint use back of the sheet if needed:

Health History (surgeries, fractures, accidents, serious illnesses, conditions etc.) use back of the sheet if needed:

Present medications – use back of the sheet if needed: _____

Is there anything else related to your health that you would like Dr. Indelicato to know?

FILL OUT ONLY FOR INJURY RELATED TO A CAR ACCIDENT:

Insurance carrier for vehicle you were in: _____

Policy No. _____ Claim No. if reported: _____ Date of Accident: _____

Driver of vehicle if you were a passenger: _____ Have you retained an attorney? _____

Name and Phone No. of Insurance Adjuster: _____

Name and Phone No. of Attorney (if applicable) _____

FILL OUT ONLY FOR WORK-RELATED INJURY:

Date of Accident: _____ Was it reported: Yes / No (circle)

Name and Address of Employer: _____

Did you stay at work? Yes / No (circle) If no, when did you return to work? _____

Name and Phone No. of Supervisor etc.: _____

Did you consult a Physician? Yes / No

If yes, name and specialty of Doctor: _____

Did you retain an attorney? Yes / No (circle)

If yes, the Name and Phone No. _____

Have you ever had a Workers' Comp claim before? Yes / No – If so, when? _____

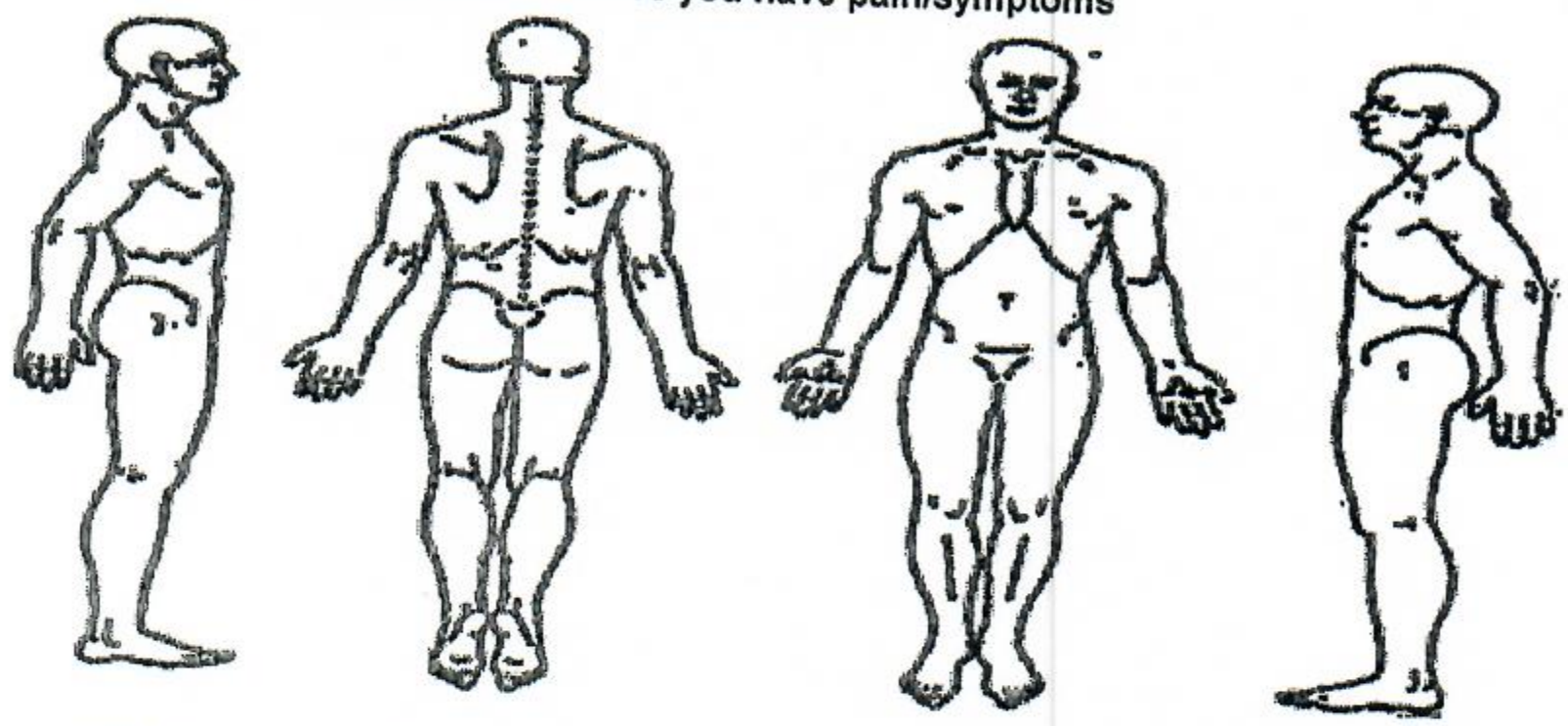
Butterfly Family Chiropractic
645 E Venice Ave
Venice, FL 34285
941-484-0008

PATIENT INTAKE FORM

Patient Name: _____ Date: _____

1. Is today's problem caused by: ◻ Auto Accident ◻ Workers Compensation

2. Indicate on the drawings below where you have pain/symptoms



3. How often do you experience your symptoms?

◻ Constantly (76-100% of the time)
◻ Frequently (51-75% of the time)
◻ Occasionally (26-50% of the time)
◻ Intermittently (1-25% of the time)

4. How would you describe the type of pain?

◻ Sharp
◻ Dull
◻ Diffuse
◻ Achy
◻ Burning
◻ Shooting
◻ Stiff
◻ Numb
◻ Tingly
◻ Sharp with motion
◻ Shooting with motion
◻ Stabbing with motion
◻ Electric like with motion
◻ Other:_____

5. How are your symptoms changing with time?

◻ Getting Worse ◻ Staying the Same ◻ Getting Better

6. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (*Please circle*)

7. How much has the problem interfered with your work?

◻ Not at all ◻ A little bit ◻ Moderately ◻ Quite a bit ◻ Extremely

8. How much has the problem interfered with your social activities?

◻ Not at all ◻ A little bit ◻ Moderately Quite a bit ◻ Extremely

9. Who else have you seen for your problem?

◻ Chiropractor
◻ ER physician
◻ Massage Therapist
◻ Neurologist
◻ Orthopedist
◻ Physical Therapist
◻ Primary Care Physician
◻ Other:_____
◻ No one

10. How long have you had this problem? _____

11. How do you think your problem began?

_____

12. Do you consider this problem to be severe?

◻ Yes ◻ Yes, at times ◻ No

13. What aggravates your problem?

_____

13a. What decreases your problem? Please state BOTH.

_____

14. What concerns you the most about your problem; what does it prevent you from doing?

_____

15. What is your: Height_____ **Weight** _____ **Date of Birth** _____

Occupation _____

16. How would you rate your overall Health?
□ Excellent □ Very Good □ Good □ Fair □ Poor

17. What type of exercise do you do?
□ Stenuous □ Moderate □ Light □ None

18. Indicate if you have any immediate family members with any of the following:
□ Rheumatoid Arthritis □ Diabetes □ Lupus
□ Heart Problems □ Cancer □ ALS

19. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present		Past	Present		Past	Present	
□	□	Headaches	□	□	High Blood Pressure	□	□	Diabetes
□	□	Neck Pain	□	□	Heart Attack	□	□	Excessive Thirst
□	□	Upper Back Pain	□	□	Chest Pains	□	□	Frequent Urination
□	□	Mid Back Pain	□	□	Stroke	□	□	Smoking/Tobacco Use
□	□	Low Back Pain	□	□	Angina	□	□	Drug/Alcohol Dependance
□	□	Shoulder Pain	□	□	Kidney Stones	□	□	Allergies
□	□	Elbow/Upper Arm Pain	□	□	Kidney Disorders	□	□	Depression
□	□	Wrist Pain	□	□	Bladder Infection	□	□	Systemic Lupus
have a Pacemaker or any electrical device?								
□	□	Hand Pain	□	□	Painful Urination	□	□	Epilepsy
_____								
□	□	Hip Pain	□	□	Loss of Bladder Control	□	□	Dermatitis/Eczema/Rash
□	□	Upper Leg Pain	□	□	Prostate Problems	□	□	HIV/AIDS
□	□	Knee Pain	□	□	Abnormal Weight Gain/Loss			
□	□	Ankle/Foot Pain	□	□	Loss of Appetite		**For Females Only**	
□	□	Jaw Pain	□	□	Abdominal Pain	□	□	Birth Control Pills
□	□	Joint Pain/Stiffness	□	□	Ulcer	□	□	Hormonal Replacement
□	□	Arthritis	□	□	Hepatitis	□	□	Pregnancy
□	□	Rheumatoid Arthritis	□	□	Liver/Gall Bladder Disorder			
□	□	Cancer	□	□	General Fatigue			
□	□	Tumor	□	□	Muscular Incoordination			
□	□	Asthma	□	□	Visual Disturbances			
□	□	Chronic Sinusitis	□	□	Dizziness			
□	□	Other:_____						

When was your last medical check up?
_____

20. List all prescription medications you are currently taking:
_____

21. List all of the over-the-counter medications AND vitamins you are currently taking:
_____

22. List all surgical procedures you have had:
_____

23. What activities do you do at work?

□ **Sit:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Stand:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Computer work:**	□ Most of the day	□ Half the day	□ A little of the day
□ **On the phone:**	□ Most of the day	□ Half of the day	□ A little of the day

24. What activities do you do outside of work?
_____

25. Have you ever been hospitalized? □ No □ Yes
if yes, why _____

26. Have you had significant past trauma? □ No □ Yes

27. Anything else pertinent to your visit today?_____Did you receive Chiropractic care before when?_____

Patient Signature_____ **Date:**_____

Butterfly Family Chiropractic Center
645 E. Venice Ave.
Venice, FL 34285
Tel (941) 484-0008

Motor Vehicle Collision Form

Patient's Name:_____ **Date:**____/_____/_____

1) **Date of the Auto Accident:** _____/_____/_____

2) **Time of the Accident:** _____:_____ **am / pm**

3) **Number of vehicles involved in the accident:** _____

4) **What road/City/State were you traveling?** _____

5) **What direction were you traveling in?** _____

6) **As a result of the accident were traffic citations issued to you/other car?** _____

7) **Please choose the primary type of impact (circle all that apply):**
Behind Left Side Right Side Front

8) **Where were you sitting in the vehicle?**
Driver Passenger Pedestrian

9) **Did you know the accident was coming?** _____

10) **At the time of impact, your vehicle was (circle all that apply):**
Slowing down Gaining speed Stopped Moving at a steady speed

11) **During and after the crash, what happened to your vehicle:** _____

12) **Did you lose consciousness during the accident? Yes No**

13) **How was your head positioned during the accident?** _____

14) **How was your torso positioned during the accident?** _____

15) **How were your hands positioned during the accident?** _____

16) **Did your head or any other bodily part hit any of the following (circle all that apply)?**
Windshield Steering wheel Side door Dashboard Ceiling
Seat Other:_____

17) **Did you have your seat belt on? Yes No**

17A) Was your airbag deployed? Yes No

18) Were Police/EMT's on scene of the accident? Yes No

19) Did you go to the hospital? Yes No

20) Name of hospital: _____

21) How did you go to the hospital? _____

22) Were you hospitalized overnight? Yes No

23) At the hospital, were you prescribed pain medication? Yes No

24) At the hospital, were you prescribed muscle relaxers? Yes No

25) Did you receive stitches for any cuts? Yes No

26) Did you receive any of the following (circle all that apply)?

Cervical Collar Back Brace

27) Were x-rays taken at the hospital? Yes No

28) Was an MRI performed? Yes No

29) Did you receive any other special imaging? Yes No

30) Have you lost any days from work? Yes No If so how many? _____

31) Since the accident have you noticed any of the following symptoms (circle all that apply)?

Headaches	Neck Pain	Neck Stiff
Tension	Back Pain	Sleeping problem
Shortness of breath	Irritability	Dizziness
Head feels heavy	Ears ring	Fainting
Pins & Needles in arms	Nervousness	Hands cold
Pins & Needles in legs	Feet cold	Numbness
Light bothers eyes	Face flushed	Fatigue
Buzzing in ears	Constipation	Cold sweats
Loss of smell	Diarrhea	Fever
Loss of balance	Stomach upset	Loss of memory

Other Symptoms: _____

Patient Signature: _____ Date: _____

Back Index

Form BI100

rev 3/27/2003

Patient Name _____ **Date** _____

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ The pain comes and goes and is very mild.
① The pain is mild and does not vary much.
② The pain comes and goes and is moderate.
③ The pain is moderate and does not vary much.
④ The pain comes and goes and is very severe.
⑤ The pain is very severe and does not vary much.

Sleeping

⓪ I get no pain in bed.
① I get pain in bed but it does not prevent me from sleeping well.
② Because of pain my normal sleep is reduced by less than 25%.
③ Because of pain my normal sleep is reduced by less than 50%.
④ Because of pain my normal sleep is reduced by less than 75%.
⑤ Pain prevents me from sleeping at all.

Sitting

⓪ I can sit in any chair as long as I like.
① I can only sit in my favorite chair as long as I like.
② Pain prevents me from sitting more than 1 hour.
③ Pain prevents me from sitting more than 1/2 hour.
④ Pain prevents me from sitting more than 10 minutes.
⑤ I avoid sitting because it increases pain immediately.

Standing

⓪ I can stand as long as I want without pain.
① I have some pain while standing but it does not increase with time.
② I cannot stand for longer than 1 hour without increasing pain.
③ I cannot stand for longer than 1/2 hour without increasing pain.
④ I cannot stand for longer than 10 minutes without increasing pain.
⑤ I avoid standing because it increases pain immediately.

Walking

⓪ I have no pain while walking.
① I have some pain while walking but it doesn't increase with distance.
② I cannot walk more than 1 mile without increasing pain.
③ I cannot walk more than 1/2 mile without increasing pain.
④ I cannot walk more than 1/4 mile without increasing pain.
⑤ I cannot walk at all without increasing pain.

Personal Care

⓪ I do not have to change my way of washing or dressing in order to avoid pain.
① I do not normally change my way of washing or dressing even though it causes some pain.
② Washing and dressing increases the pain but I manage not to change my way of doing it.
③ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
④ Because of the pain I am unable to do some washing and dressing without help.
⑤ Because of the pain I am unable to do any washing and dressing without help.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor.
③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
⑤ I can only lift very light weights.

Traveling

⓪ I get no pain while traveling.
① I get some pain while traveling but none of my usual forms of travel make it worse.
② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
③ I get extra pain while traveling which causes me to seek alternate forms of travel.
④ Pain restricts all forms of travel except that done while lying down.
⑤ Pain restricts all forms of travel.

Social Life

⓪ My social life is normal and gives me no extra pain.
① My social life is normal but increases the degree of pain.
② Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
③ Pain has restricted my social life and I do not go out very often.
④ Pain has restricted my social life to my home.
⑤ I have hardly any social life because of the pain.

Changing degree of pain

⓪ My pain is rapidly getting better.
① My pain fluctuates but overall is definitely getting better.
② My pain seems to be getting better but improvement is slow.
③ My pain is neither getting better or worse.
④ My pain is gradually worsening.
⑤ My pain is rapidly worsening.

Sign: _____

Back Index Score ☐

Neck Index

Form N1-100

rev 3/27/2003

Patient Name _____ **Date** _____

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ I have no pain at the moment.
① The pain is very mild at the moment.
② The pain comes and goes and is moderate.
③ The pain is fairly severe at the moment.
④ The pain is very severe at the moment.
⑤ The pain is the worst imaginable at the moment.

Sleeping

⓪ I have no trouble sleeping.
① My sleep is slightly disturbed (less than 1 hour sleepless).
② My sleep is mildly disturbed (1-2 hours sleepless).
③ My sleep is moderately disturbed (2-3 hours sleepless).
④ My sleep is greatly disturbed (3-5 hours sleepless).
⑤ My sleep is completely disturbed (5-7 hours sleepless).

Reading

⓪ I can read as much as I want with no neck pain.
① I can read as much as I want with slight neck pain.
② I can read as much as I want with moderate neck pain.
③ I cannot read as much as I want because of moderate neck pain.
④ I can hardly read at all because of severe neck pain.
⑤ I cannot read at all because of neck pain.

Concentration

⓪ I can concentrate fully when I want with no difficulty.
① I can concentrate fully when I want with slight difficulty.
② I have a fair degree of difficulty concentrating when I want.
③ I have a lot of difficulty concentrating when I want.
④ I have a great deal of difficulty concentrating when I want.
⑤ I cannot concentrate at all.

Work

⓪ I can do as much work as I want.
① I can only do my usual work but no more.
② I can only do most of my usual work but no more.
③ I cannot do my usual work.
④ I can hardly do any work at all.
⑤ I cannot do any work at all.

Personal Care

⓪ I can look after myself normally without causing extra pain.
① I can look after myself normally but it causes extra pain.
② It is painful to look after myself and I am slow and careful.
③ I need some help but I manage most of my personal care.
④ I need help every day in most aspects of self care.
⑤ I do not get dressed, I wash with difficulty and stay in bed.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
④ I can only lift very light weights.
⑤ I cannot lift or carry anything at all.

Driving

⓪ I can drive my car without any neck pain.
① I can drive my car as long as I want with slight neck pain.
② I can drive my car as long as I want with moderate neck pain.
③ I cannot drive my car as long as I want because of moderate neck pain.
④ I can hardly drive at all because of severe neck pain.
⑤ I cannot drive my car at all because of neck pain.

Recreation

⓪ I am able to engage in all my recreation activities without neck pain.
① I am able to engage in all my usual recreation activities with some neck pain.
② I am able to engage in most but not all my usual recreation activities because of neck pain.
③ I am only able to engage in a few of my usual recreation activities because of neck pain.
④ I can hardly do any recreation activities because of neck pain.
⑤ I cannot do any recreation activities at all.

Headaches

⓪ I have no headaches at all.
① I have slight headaches which come infrequently.
② I have moderate headaches which come infrequently.
③ I have moderate headaches which come frequently.
④ I have severe headaches which come frequently.
⑤ I have headaches almost all the time.

Sign: _____

Neck Index Score ☐

Standard Disclosure and Acknowledgement Form
Personal Injury Protection - Initial Treatment or Service Provided

The undersigned insured person (or guardian of such person) affirms:

1. The services or treatment set forth below were **actually rendered.** This means that those services have **already been provided.**

_____

_____

2. I have the right and the **duty to confirm** that the services have already been provided.

3. I was **not solicited** by any person to seek any services from the medical provider of the services described above.

4. The medical provider has **explained** the services to me for which payment is being claimed.

5. If I notify the insurer in writing of a billing error, I may be entitled to a portion of any reduction in the amounts paid by my motor vehicle insurer. If entitled, my share would be at least 20% of the amount of the reduction, up to $500.

Insured Person (patient receiving treatment or services) or Guardian of Insured Person:

_____	_____	_____
Name *(PRINT or TYPE)*	Signature	Date

The undersigned licensed medical professional or medical director, if applicable, affirms the statement numbered 1 above and also:

A. I have **not solicited** or caused the insured person, who was involved in a motor vehicle accident, to be solicited to make a claim for Personal Injury Protection benefits.

B. The treatment or services rendered were explained to the insured person, or his or her guardian, **sufficiently** for that person to sign this form with informed consent.

C. The accompanying statement or bill is **properly completed** in all material provisions and all relevant information has been provided therein. This means that each request for information has been responded to **truthfully, accurately,** and in a **substantially complete** manner.

D. The coding of procedures on the accompanying statement or bill is proper. This means that **no service has been upcoded, unbundled,** or constitutes an invalid **or not medically necessary diagnostic test** as defined by Section 627.732 (15) and (16), Florida Statutes or Section 627.736(5)(b)6, Florida Statutes.

Licensed Medical Professional Rendering Treatment/Services or Medical Director, if applicable *(Signature by his/ her own hand)*:

_____	_____	_____
Name *(PRINT or TYPE)*	Signature	Date

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree. [illegible] Section 817.234(11)(b), Florida Statutes.

Note: The original of this form must be furnished to the insurer pursuant to Section 627.736(4)(b), Florida Statutes and may not be electronically furnished. Failure to furnish this form may result in non-payment of the claim.

Butterfly Family Chiropractic
645 E. Venice Ave.
Venice, FL 34285
941-484-0008

ASSIGNMENT OF INSURANCE BENEFITS, LIEN, RELEASE, & DEMAND

Insurer and Patient Please Read the Following in its Entirety Carefully!

I, the undersigned patient/insured knowingly, voluntarily and intentionally irrevocably assign the rights and benefits of my automobile Insurance, also known as Personal Injury Protection (hereinafter PIP), Uninsured Motorist and Medical Payments policy of insurance to the above health care provider. I understand it is the intention of the provider to accept this assignment of benefits in lieu of demanding payment at the time services are rendered. I understand this document will allow the provider to file suit against an insurer for payment of the insurance benefits or an explanation of benefits and to seek §627.428 damages from the insurer. This assignment of benefits includes transportation, medications, 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 provider in writing within five days of receipt of this document. Failure to inform the provider shall result in a waiver by the insurer to contest the validity of this document. Failure to inform the provider shall result in a waiver by the insurer to contest the validity of this document. The undersigned directs the insurer to pay the health care provider the maximum amount directly without any reductions & without including the patient's name on the check. To the extent the PIP insurer contends there is a material misrepresentation on the application for insurance resulting in the policy of insurance is declared voided, rescinded, or canceled, I as he named insured under said policy of insurance, hereby assign the right to receive the premiums paid for my PIP insurance to this provider and to file suit for recovery of the premiums. The insurer is directed to issue such a refund check payable to this provider only. Should the medical bills not exceed the premium refunded, then the provider is directed to mail the patient/named insured a check which represents the difference between the medical bills and the premiums paid.

Lien: I, the undersigned patient guarantee full payment to _____ (Provider's Business Name) and agree that I will remain personally responsible for unpaid charges as a result of any deductible, co-payment, and treatment after benefits are exhausted and/or for any other treatment/service that remains unpaid. Furthermore, I grant _____(Provider's Business Name) a lien against any recovery, which I may have against any tortfeasor, responsible party, or any responsible insurance carrier. I direct my attorney to withhold any funds I receive from any settlement to pay for any outstanding balance to _____(Provider's Business Name). I agree to and instruct my attorney to promptly advise _____ (Provider's Business Name) of any settlement as a result of the injuries sustained in the _____(Date) motor vehicle accident, slip-n-fall, or motorcycle accident. Additionally, I agree and instruct my attorney that I will not accept any settlement check until the remaining balance is resolved with _____(Provider's Business Name).

Disputes: The insurer is directed by the provider and the undersigned to not 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 has been a prior written settlement agreed to by the health provider (specifically the office manager) and the insurer as to the amount payable under the insurance policy. The insured and provider hereby contests and objects to any reductions or partial payments. Any partial or reduced payment, regardless of the accompanying language, issued by the insurer and deposited by the 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 provider to accept a reduced amount as payment in full. The insurer is hereby placed on notice that this provider reserves the right to seek the full amount of the bills submitted. If the PIP insurer states it can pay claims at 200% of the Medicare Fee Schedule or any other fee schedule contained within F.S. 627.736 then the insurer is instructed & directed to provide this provider with a copy of the policy of insurance within 10 days. Any effort by the insurer to pay a disputed debt as full satisfaction must be mailed to the address above, after speaking with the office/billing manager and mailed to the attention of the office/billing manager. *See Fla. Stat. §673.3111.*

This assignment applies to both past and future medical expenses and is valid even if undated. A photocopy of this assignment is to be considered as valid as the original. I agree to pay any applicable deductible, co-payments, for services rendered after the policy of insurance exhausts and for any other services unrelated to the automobile accident. The health care provider is given the power of attorney to: endorse my name on any check for services rendered by the above provider; and to request and obtain a copy of any statements or examinations under oath given by patient.

Release of information: I hereby authorize this provider to: furnish an insurer, an insurer's intermediary, the patient's other medical providers, and the patient's attorney via mail, fax, or email, with any and all information that may be contained in the medical records; and for my insurance carrier to **send insurance coverage information (declaration sheet & policy of insurance) in writing and telephonically to the above-named provider**; request from any insurer all explanation of benefits (EOBs) for all providers and non-redacted PIP payout sheets; obtain any written and verbal statements the patient 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, and MRIs, from any other medical provider or any insurer. The provider is permitted to produce my medical records to its attorney in connection with any pending lawsuits. The insurer is directed to keep the patient's medical records from this provider private and confidential. The insurer is not authorized to provide these medical records to anyone without the patient's and the provider's prior express written permission. **PLEASE NOTE: The insurer is not authorized to release protected health information (PHI) to third party vendors that schedule independent medical examinations or independent medical examination physicians.**

Demand: Demand is hereby made for the insurer to pay all bills within 30 days without reductions and to mail the latest non-redacted PIP payout sheet and the insurance coverage declaration sheet, and the insurance policy to the above provider within 15 days, as well as notify the provider pursuant to F.S. 627.736(6)(f) when benefits have been exhausted. The insurer is directed to pay the bills in the order they are received. However, if a bill from this provider and a claim from anyone else is received by the insurer on the same day the insurer is directed to not apply this provider's bill to the deductible. If a bill from this provider and claim from anyone else is received by the insurer on the same day then the insurer is directed to pay this provider first before the policy is exhausted. The insurer is instructed to inform, in writing, the provider of any dispute.

Caution: Please read before signing. If you do not completely understand this document please ask us to explain it to you. If you sign below we will assume you understand and agree to the above. I certify that I have read and agree to all of the above and was not solicited or promised anything in exchange for receiving health care. I agree that the prices for the medical care is reasonable.

Patient's Name _____ Patient's Signature _____
(Please Print) (If patient is a minor, signature of parent/guardian)

Date _____

CHIROPRACTIC INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays and/or other tests on me (or the patient named below, for whom I am legally responsible) by the doctor or chiropractor named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor or chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations, falls, dizziness, headaches, burns with modalities and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, and is in my best interests.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment

Dr. Joseph Indelicato

X

Patient Signature – or signature of Patient's Representative

Date

[Indicate relationship if signing for the patient _____]

ACKNOWLEDGMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided 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 and maintained for six years.

By checking the lines below I authorize being contacted for practice reminders by:
Mail _____;
Email_____; at email address
_____;
Telephone numbers_____;
_____;
By voice mail _____;
By text message _____;
By FaceBook address _____.

By checking this checking the lines below I authorize being contacted for birthday greetings or promotions about the practice by:
Mail _____;
Email _____ at email address
_____;
Telephone numbers_____;
_____;
By voice mail _____;
By text message _____;
By FaceBook address _____.

By checking this checking the lines below I authorize the doctor to personally discuss with me products that may benefit my health or condition.

_____ _____
Patient Name (please print) Date

_____
Name of Parent, Guardian or Patient's legal representative

_____
Signature of Patient, Parent, Guardian or Patient's legal representative

THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS.

List below the names and relationship of people to whom you authorize the Practice to release PHI.

BUTTERFLY FAMILY CHIROPRACTIC
645 EAST VENICE AVE
VENICE, FL 34285

Addendum:

Open Room: We utilize an open therapy room. We make good faith attempts to keep our conversations at a low level. We offer every patient the opportunity to be treated in a private room if requested

Sign_____

Date_____